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EVALUATION
OF
MENTAL HEALTH SERVICES

VOLUME II

THE ISSUES

Office of Program Evaluation
Alameda County
June, 1976

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EVALUATION OF MENTAL HEALTH SERVICES VOLUME II:

THE MAJOR ISSUES

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The OPE evaluation of Mental Health Services required enormous effort and commitment from the evaluation team. A comprehensive effort of this kind means many, many hours and much creativity. We want to thank the evaluation team for their efforts over the past seven months:

Phil Broemel	Mental Health Services
Elizabeth Kearns	on assignment to OPE from Graduate School of Public Policy, UC Berkeley
Jesse Lucas	Director, Laurel House
Lucy Rosenblum	Auditor - Controllers' Office
James Sorrells	Mental Health Services
Frank White	Personnel Department
Kay White	Probation Department

Throughout the evaluation, the cooperation of many individuals was necessary. We thank here the people - too numerous to mention - who assisted us and provided the access and information needed to undertake this evaluation.

Matthew Golden, Director
Peter Henschel, Assistant and Team Leader
Office of Program Evaluation

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Section I

A. Introduction to the Evaluation: Intent, Scope, and Expectations

In July, 1975, the Board of Supervisors of Alameda County requested that the Office of Program Evaluation undertake a six-month evaluation of the County-operated and contracted Mental Health Services. The focus of this effort, as requested, was to:

Examine the total delivery system in terms of efficiency and the impact of select program areas and provide conclusions and recommendations to the County Board, the Mental Health Service, and the directors of each mental health program.

The evaluation is designed to assist the County Board, the CAO, and the Mental Health Service in making decisions on the allocation of staff and financial resources, by providing information on the status of our mental health services, and by providing constructive feedback to individual mental health program regarding their operations.

B. The Evaluation Process

The Office of Program Evaluation utilized an eight-member team to undertake this evaluation. Peter Henschel, Assistant to the Director of OPE, managed the evaluation process with additional full and part-time team members taken from County and contract agencies, including representatives from mental health services. The evaluation team worked from September 8, 1975, through April 9, 1976, in the preparation of the reports.

the first time I
had seen him
I had been
impressed by
his physical
strength and
his good
manners.
He was
a tall man,
with a
dark complexion
and dark hair.
He had a
kindly
face and
a gentle
manner.
He was
a good
man and
I liked
him very
much.

The team began the evaluation process by conducting a thorough overview of the County's Mental Health Services and reviewing available literature on mental health evaluation methodologies and experiences in other settings. The overview process included a review of all materials and interviews with all chiefs of mental health services - County and contract - and selected administrative staff. District Advisory Committees, the Mental Health Advisory Board, and the Mental Health Association of Alameda County were also included in our initial contacts.

At the outset, OPE established an Ad Hoc Advisory Committee of service providers (including contractors) and District Citizen Advisory Committee representatives to advise the evaluation team throughout the course of the evaluation. The committee assisted the evaluation team especially in the development of the final work program and reaction to preliminary findings.

After the overview was completed, the team examined the data, and incorporated the evaluation priorities solicited from service chiefs, staff, administrators, and advisory groups. Out of this process came a preliminary work plan which, after review with the Ad Hoc Advisory Committee, became the final plan for the evaluation.

Eight priority areas were identified during the overview process. Each was described with a statement of definition, a hypothesis regarding the status of the mental health services in that area, the objectives of the evaluation, and a statement of why the issue was important. The priority issues for review were (see next page):



Quality	Administrative and Financial Support
Impact	Billing and Liability
Cost and Productivity	Linkages To Other Service Providers
Management	State Hospital Utilization

The assumptions, methodologies, and findings for each of the eight issues are presented at the beginning of the discussion of each issue in Volume II. A summary of the conclusions and recommendations begins each section. Volume III applies the relevant issues to the analysis of individual service delivery sites.

C. How To Use This Report

The OPE evaluation of mental health services is contained in three distinct volumes. The focus of these three volumes is as follows:

Volume I

- An Action Document, reflecting the major conclusions and recommendations - system wide - and designed to ask and answer the critical questions of "what does it all mean?"

Volume II

- Addresses key issues in the final work program. This document goes through the conclusions and recommendations for each of the major issues plus details the evidence and justification.

Volume III

- Designed to relate primarily to the individual mental health service sites, program directors, and staff.

This volume is, in fact, 42 separate assessments. Discussion is brief and specifically provides the conclusions and recommendations, plus supporting data for each of the major issues for which site-specific information was collected. This includes Quality, Impact, Productivity, and Management.



For Volume II, each section represents one of the eight issues.

Each issue is discussed in relation to the points raised in the final work plan (November, 1975). A summary of the conclusions and recommendations is provided prior to the analysis of each area in order to simplify quick perusal. A detailed recitation of these conclusions and recommendations is then followed by the accompanying support data for each set. This organization should facilitate the reading and comprehension of the report.

Since the outlines of Volumes II and III are virtually identical, the reader can easily cross-reference between them to attain, for example, the system-wide conclusions and recommendation for a specific priority issue - say, Quality - while seeing these system-wide (Volume II) statements in the context of a specific mental health program (Volume III).



Section II

What the Issues Tell us: Synopsis of Findings

A. Introduction

Our approach throughout this evaluation has been to look at the mental health services of Alameda County from the "bottom up". The results of our evaluations of 50 different service sites revealed patterns that exist in the major issues of quality, impact, productivity, management, billing, administrative, and financial support and linkages to other services. We looked for patterns of strength, or weakness and identified the main reasons for present conditions. The results of the process are expressed as conclusions and recommendations under each of the key issues in Volume II. In this section, we will go beyond the results for each issue and speak to the recurring patterns or threads that appear to affect the fabric of the entire mental health program and delivery system.

B. What The Issues Tell Us

1. Setting

The Mental Health Service is a relatively new department and, in 1975, looks quite different than it did as recently as 1973. Few of the outpatient services are over three years old, most contracted services did not exist, and the entire operation was comparatively small. Three years ago, County Mental Health Services meant Highland and Fairmont Hospitals and little else.



Today, at least 50 different services constitute the mental health program of Alameda County. Much of this growth is a function of State requirements for 90% State funding of mental health programs under the Lanterman-Petris-Short Act. By State mandate, each California county, as the service provider, must provide specific services (modalities) and has to move toward increasing community provision of mental health services and away from State hospital utilization. The requirements of LPS forced our County to expand its services rapidly, with 90% State funding, and to deliver services to new sectors of the population.

The growth of mental health services happened concurrently with the move toward a super-agency for all health-related services in Alameda County. As mental health became part of the Health Care Services Agency, demands for integration of services at the program level grew and both the Director of the Health Care Services Agency and the former Director of Mental Health Services faced pressure to provide visible, integrated services as part of the rationale for a health care services agency.

Although events moved quickly and State funding appeared to be supporting most activities, the management of the mental health service did not grow to meet the challenges placed before it. Leadership did not emerge, either within the Mental Health Service or at the top of the Health Care Services Agency. In fact, the organization of HCSA vis-a-vis mental health services created an



explicit separation between authority, responsibility and accountability for management, innovation, and leadership. The roles given individuals often separated these key characteristics of good management.

While pressures for service increased and the mental health program grew, the organization for delivery separated even more the roles for authority, responsibility, and accountability; people were asked to perform tasks for which they did not have authority and for which, in the final analysis, they were not accountable. The districting of mental health services - designed to move services closer to the community - simply placed another barrier between client needs and the responsiveness of mental health services.

Throughout this period, few personnel felt they held authority to make decisions, and few incentives existed to act decisively. The former mental health director, separated from direct-line responsibility for mental health found it difficult to delegate authority to the districts; concurrently the agency director did not aggressively look after the needs of the mental health service. In this environment, the mental health service operated, without objectives, and without measures to assess success or expectations.

Services integration and coordination was not successful because:

1. Attempts at "bottom line" integration were not systematically or organizationally supported by department heads within the agency.
2. The Health Care Agency Director did not encourage or promote efforts at coordination nor provide the leadership to create incentives to integrate and communicate across programs.



3. There is no current vehicle at the top levels of the Agency to deal with broad health care issues policies and problems.
4. Health Care Agency administrative services are a major procedural constraint and a cost factor to mental health services.

Thus, in June, 1975, the new mental health director took over and faced a real challenge in creating a cohesive mental health service delivery system. The lack of leadership and clearly delineated authority created a scattering of services, disconnected from their settings and from each other. Contracting for mental health services evolved as a means to make services more relevant; contractors would function in the areas of greatest vulnerability. Yet there was no overall service delivery plan or context in which contractors were expected to fit.

The present low staff morale and administration defensiveness is a by-product of the preceding administrative difficulties.

The lack of recognizable objectives with specific expectations, allowed line staff to operate in small vacuums with minimal incentive to innovate, to suggest, or to act, for no one had responsibility to make decisions.

Much of this can be attributed to an administrative concern over organization structure rather than objective-focused delivery for a diverse urban population.

It is in this context that basically committed and competent staff, as individuals, try to deliver services. It is also in this context that your Board should examine the threads that weave through our evaluation of the Mental Health Service.



2. Recurring Themes

Our examination and analysis of mental health services covers seven major issues, 50 sites and many conditions. The evaluation team has identified threads that run throughout the fabric of the present mental health service, transcend any single issue, and, in one way or another, are the sources of most of the difficulties that our evaluation has outlined in Volumes II and III.

What follows is a profile of those threads or patterns that appear in more than one of the seven major issues. Our evaluation indicates that:

- Many staff provide services of substantial benefit and exhibit competence and creativity despite many management and procedural constraints.
- No clear objectives exist by which the Agency, mental health services or individual clinicians can measure success and progress toward accepted goals.
- No one knows what is expected of them - whether it be the Health Care Agency, mental health services or specific staff.
- Management, is crisis-oriented rather than related to objectives or plans.
- The lack of clear expectations and objectives has inhibited staff innovation, creativity, client advocacy, initiative, coordination, liaison, productivity, and continuity of care.
- Few rigorous needs assessments have been done within the agency by which resource allocation decisions can be pegged and difficult funding and service delivery choices can be made.



- An overall program design needs to be developed. There is not a system through which mental health services are delivered; only scattered sites that provide specific, often narrow, services to specific types of clientele.
- There exist conflicting directions and few shared goals - especially between County-operated and contract programs.
- Genuine performance monitoring and evaluation needs to be developed and emphasized particularly in relation to contractors.
- Morale in County-operated programs is very low. An extraordinary degree of alienation and cynicism exists at the line staff and service chief levels.
- Mental Health Services - as a program - is not taken seriously by other County programs, within the State mental health community, by HCSA, or by the mental health program itself. This has surfaced in a defeatist attitude. The continuing presence of supposedly community oriented mental health services within County hospitals is a major source of the present problem.
- The Health Care Services Agency needs to develop a supportive and positive influence toward mental health services. Finance administration is poor and most HCSA actions fail to meet the needs of mental health. Mental health staff believes that HCSA provides little meaningful support to mental health, and may, in fact, simply use mental health Short-Doyle funds to subsidize the County hospitals. This belief is another key reason for the lack of pride or esprit among staff in County services.
- Little rationale exists by which staff resources and skills are matched to client and community needs.
- Many staff are underutilized, both in terms of time and skills; others are asked to do more than their training prepares them.
- The present organization of services by modalities (day treatment, rehab, crisis, etc.) has fostered conflicts and has reduced client accessibility, since clients have to select and find the most appropriate plan on their own.



- Multidisiplinary approaches to problems or services are rare; few truly integrated services with shared staffing exist anywhere in the County system.
- Linkages between mental health and other service providers are virtually non-existent. Again, no one has had a clear mandate to make the links necessary for service coordination at the program level.
- There are few positive re-enforcements to foster creativity, innovation, or thinking beyond the domain of a specific service. The present system has bureaucratic punishments for action taken outside of the service's domain. The client is not served as a whole person. The infrequency of client advocacy is an example.
- The nature of State funding for drug, alcohol, and mental health services fosters a compartmentalization of services - thereby inhibiting true services integration at the program level.
- Differences do exist between County-operated and contract services, the differences are mainly in the ability of contract services to be flexible, mobile, and to have a greater control over their environment. Contractors tend to be more accessible to clients. However, although differences exist, our evidence indicates that no major pattern of difference exists between County and contract programs in terms of their impact, productivity, cost, quality, and management.

Discussion

The message to our evaluation team is clear; the lack of reference points and expectations has had serious effects on the ability of staff to function at a level consistent with capabilities and challenges. There is no common sense of purpose. The agency staff are told to worry about Napa utilization while contract programs fail to place high priority on the hospitalization utilization issue at all. The lack of expectations and a shared



sense of community and purpose may be the single largest factor to account for the low productivity of the County-operated and contract services. 59% of all County-operated and contract programs have over 50% of their staff time unallocated to either direct or indirect services.

Also, the lack of any motivation to rigorously pursue revenues has cost the mental health program at least \$793,900 in revenues for 1974-75 alone. The amount for 1975-76 is estimated by our team to approach \$1,118,600 if the trend continues. These are but a few examples.

3. The Recurring Theme

Simply stated, the single theme that recurs throughout the evaluation is that ALAMEDA COUNTY DOES NOT HAVE AN INTEGRATED SERVICE DELIVERY SYSTEM BASED ON THE COMMUNITY MENTAL HEALTH CENTER MODEL, despite State requirements, citizen pressures, and staff expectations. Yet, our evaluation found, both in a qualitative and quantitative sense, that the staff of our County and contract services are, for the most part, dedicated, sophisticated, and competent clinicians and workers. Our observations and interviews indicate this, but, more importantly, the results of our analysis of the impact of the services points to substantial benefit for clients served by the present staff. The quality of the clinicians/clients relationship may well be sustained in spite of the problems of our Mental Health Services and their environment.



QUALITY



Summary
of
Findings and Conclusions

1. Accessibility

- The phone book and Directory Assistance are inadequate routes to mental health services.
- Telephone reception itself is generally good in most mental health programs. Contractors achieve a higher level of excellence, however.
- The client's place of residence is still a barrier to service in Alameda County.
- Reception services at program sites are generally good.
- Screening, information and referral services in most programs are seriously impaired by improper definition of clerical versus clinical roles.
- The location of outpatient programs in County hospital settings is a major barrier to accessibility.
- The location of Psychiatric Emergency within Highland Hospital is grossly inappropriate.
- The location of Eden Rehabilitation, Valley Outpatient, and Berkeley Crisis programs at their present sites present serious barriers to accessibility.
- Hours of operation of Crisis programs are inadequate to community needs. No formal assessment of needs has been made by Mental Health Services.
- Rehabilitation and Children's outpatient programs need increased evening and weekend hours.
- Fairmont Psychiatric Emergency needs 24-hour operations.
- Cultural and ethnic access to mental health services have been inadequately addressed by the County. Barriers are apparent in our study, which did not include a needs assessment. Contracting of programs has helped access.
- Language barriers to services exist for clients speaking Spanish or Asian languages. Translation services within the Mental Health Services are undeveloped.

1. Accessibility (continued)

- Many physically-handicapped, especially the deaf, are inadequately served by Mental Health Services.
- An unnecessary barrier to service exists in case-opening procedures in County-operated programs.

2. Program Design

- The present division of adult services by "modalities" is a major impediment in accessibility and referral to mental health services.
- "Crisis" programs lack adequate capability for providing either crisis intervention services or a wider range of on-going clinical outpatient services. Absence of definition of services by Mental Health Administration has produced major conflicts within many programs.
- "Rehabilitation" programs provide an inadequate continuum of care, of either clinical or social rehabilitation services, because of undue separation from other adult outpatient programs.
- "Day Treatment" programs have generally outstanding clinical operations which warrant further effectiveness evaluation. Intake linkages to day treatment appear to be undeveloped from several potential sources.
- Children's programs, though generally understaffed, offer outstanding clinical and consultation services. Day treatment and residential care for children require County-wide assessment. The design of children's programs in East Oakland appears to be predicated on a separation of programs along cultural and ethnic lines which may be unduly sharp.
- Community-based programs funded by the County lack any significant degree of integration and coordination with County-operated programs. Several complicating factors include the intent of the County and the beliefs of the contractors regarding the value of cooperation and integration for underserved cultural and ethnic groups.
- Five programs are troubled by issues involving professional standards and staff competence.

3. Continuity of Care

- Case recording standards and practices in County-operated programs are for the most part poorly defined or not defined at all. Standards and practices in contract programs are supposed to be modelled on County programs, however, many contractors have well-defined standards and practices of their own.
- Recent institution of new "Brief Record" forms in County-operated Crisis and Psychiatric Emergency programs have improved drop-in services, but are inadequately linked to the Central Records system.



3. Continuity of Care (continued)

- The operation of Central Records, Highland Hospital, has long-standing inadequacies in serving mental health needs, seriously affecting continuity of care in all County-operated programs.
- Recent implementation of a new mechanism to promote referral confirmation between all mental health programs funded by the County should correct major inadequacies in continuity described by our study of referrals prior to implementation of this new mechanism. Complete implementation throughout all programs, and mechanisms for quality review, are required to insure reliable continuity.
- Use of a "center" design for programs is suggested as another means for improving continuity.
- No broad policy standards exist for referral to private mental health resources. Few programs consistently follow-up private referrals. No program mechanisms are generally used to appraise private referral results for future reference in mental health programs singly or as a group.

4. Responsiveness

- Most clients in all mental health programs are satisfied with the services they are receiving.
- A higher level of satisfaction exists in contract programs than in County-operated programs.
- Community education activities are relatively undeveloped in most mental health programs. Some children's programs and community-based contract programs are exceptions. The absence of a functional "center" design of programs is the main reason for this lack of development.



QUALITY

A. Introduction

The 1975-76 Alameda County Mental Health Plan states that "certain qualities must distinguish the service delivery system. Specifically, we seek to provide comprehensive, accessible and responsive mental health services that are integrated at the provider level and coordinated with other community care givers." Our analysis of quality addresses each of these characteristics with the exception of the last, which is addressed specifically in our Section VII, Linkages Between Mental Health and Other Services.

To define the quality of mental health services means to describe the degree to which they approach some ideal standards in any of their component parts. Issues that define quality are described in our final work program from the standpoint of clients, mental health staff, the total delivery system, and the layperson in the community. These issues in their several contexts define the quality standards and evaluation criteria of our analysis.

Quality of service delivery was addressed in several ways, including interviews of service chiefs, written surveys of chiefs, clinical and clerical staff in the programs, site observations, sample telephone calls, tracking of case records and a survey of client satisfaction.

For ease of presentation, the issue of quality is divided here into four sections: Accessibility, Program Design, Continuity of Care and Responsiveness. These sections encompass the standards and criteria outlined in our study plan from client, staff, system and layperson standpoints. Each section begins with a description of issues contained under the heading, and why they are important.



CONTENTS UNDER:

B. Findings, Conclusions and Recommendations

1. Accessibility

Introduction

- a) Telephone Accessibility
- b) District Residence
- c) Reception Services
- d) Screening, Information and Referral Services
- e) Location, Access by Public Transportation and Physical Visibility
- f) Hours of Operation
- g) Cultural or Racial Access and Welcome
- h) Language Accessibility
- i) Capability to Serve Physically Handicapped
- j) A Procedural Impediment

2. Program Design

Introduction

- a) Type of Problem Served
- b) Variety of Services Available, by "Modality"
 - Crisis Intervention Services
 - Rehabilitation Services
 - Day Treatment Services
 - Children's Services
- c) Contract Programs to Serve Ethnic and Cultural Groups
- d) Programs Troubled by Issues of Professional Standards or Competence

3. Continuity of Care

Introduction

- a) Case Recording Standards and Practices
- b) Availability of Records for County-operated Programs
- c) Referral Practices Within County-funded Programs
- d) Referral Practices Between County-funded Programs and the Private Sector

4. Responsiveness

Introduction

- a) Client Satisfaction
- b) Community Education

I. ACCESSIBILITY

b. Findings, Conclusions and Recommendations

The accessibility of mental health services is influenced by a surprising number of factors: how and if you learn about a program, its location and how to get there, how visible the building or the office in the building is once you arrive and its hours of operation. Beyond these physical factors, concerns such as: what is your reception like over the phone or in person? What kind of problem do you think you have, or are you thought to have? What does it cost and what forms must you sign? Are the people there completely different from you? If you don't speak English well, do you stand a chance of getting help? and If you are disabled, will you be able to get into the building? These are some of the many factors which are important in assessing accessibility.

WE CONCLUDE that if a citizen already knows where to call, he/she will probably get good reception, but if a citizen doesn't know where to call and uses either Directory Assistance or the telephone book, he/she will probably not get service.

Specifically:

WE CONCLUDE that telephone reception in most adult and in all children's programs is very good.

WE RECOMMEND that the level of telephone reception in those programs rated excellent or good continue. In those few programs rated "poor", we recommend that reception services be improved. (See site analyses in Volume III).

SUPPORT:

*

Telephone accessibility study, Part I, shows:

- 100% excellent or good ratings of all children's programs
- 80% excellent or good ratings of most adult programs, with the rest receiving poor ratings.

WE CONCLUDE that contractors achieve a higher standard of excellence, though there is little variance in the overall adequacy, in the quality of telephone reception between County-operated and contract mental health programs.

SUPPORT:

Part I of telephone accessibility shows:

	<u>GOOD</u>	<u>EXCELLENT</u>	<u>GOOD OR EXCELLENT</u>
All County Programs	54.5%	32%	86%
All Contract Programs	24%	60%	84%
County <u>Adult</u> Programs Only	44%	37.5%	81%
Contract <u>Adult</u> Programs Only	30%	50%	80%

WE CONCLUDE that County residents encounter great difficulty reaching help for mental health problems when calling Directory Assistance ("411").

WE RECOMMEND that Mental Health Administration decide where calls concerning mental health problems should be referred to, and that this information be communicated to the telephone company and its local Directory Assistance operators.

SUPPORT:

*

Telephone Accessibility Study part II revealed:

- no pattern of where Directory Assistants refer non-suicidal mental health calls.
- only 3 of 10 calls to Directory Assistance resulted in eventual help at any of the mental health programs in the County system.
- Several Directory Assistants indicated they were not properly trained to handle non-suicidal mental health concerns.
- 3 of 10 Directory Assistants said they just didn't know what to tell caller and after some hesitation, terminated the conversation.

WE CONCLUDE that the telephone directories are not useful to County residents in seeking mental health services.

WE RECOMMEND that a 24-hour number for mental health services be placed prominently in the inside cover of telephone books under "EMERGENCY."

WE FURTHER RECOMMEND that mental health services have multiple listings, especially for crisis programs, under "M" for Mental Health Crisis Services, in the telephone directories for each city in the County.

SUPPORT:

Telephone Accessibility Study, Part II, showed that County Mental Health Services are not listed where County residents seem to look, namely on the inside cover under "EMERGENCY" and under "M" for mental health.

(Results are based on sample calls made solely by County residents.)

a) Telephone Accessibility - Methodology and Results

This factor has two parts. First, telephone reception at any mental health program must be prepared to handle reasonable requests for information concerning a program's operations, location and how to get there, cost and inquiries regarding a client that do not violate confidentiality. To assess this factor, the evaluation team engaged in a telephone study making sample telephone calls to all programs, asking for help for a variety of mental health problems, focused on entry requirements, physical, temporal and financial accessibility.* The reception practices of all programs were then rated on a scale of excellent - good - poor. (See Part I, Table I, on page 10.) Those programs rated "poor" are reported in site analyses in Volume III with specific recommendations on how telephone reception should be improved.

* See Appendix on Telephone Accessibility and results



The second factor of telephone accessibility deals with the relative ease in, and the probable likelihood of, a person actually reaching a mental health program getting service if the person has no foreknowledge of any particular program. Two methods were used to study this:

- 1) Both the evaluation team and County residents without prior experience were asked to make sample calls to Directory Assistance, representing a mental health problem and asking where to call for help, and
- 2) County residents without prior experience were asked to do the same, beginning instead with their city telephone books and without Directory Assistance. (See Part II, table I, on page 11.)

The following tables summarize the results of the Telephone Accessibility Study:



TABLE I
RESULTS OF TELEPHONE ACCESSIBILITY
PART I

Ratings of Telephone Reception in All Programs

<u>CATERGORIES</u>	<u>Percentage of Category Rated "Excellent"</u>	<u>Percentage of Category Rated "Good"</u>	<u>Percentage of Category Rated "poor"</u>	<u>Percentage of Category which are Adequate (Excellent or good ratings)</u>
All Children Services*	54.5%	45.5%	0%	100.0%
North Region Adult Services	53.8%	29.9%	19.2%	80.7%
South Region Adult Services	20.0%	60.0%	20.0%	80.0%
All Adult Services	44.4%	36.1%	19.4%	80.5%
County-operated Including Children Services	31.8%	54.5%	13.6%	86.3%
Contractors Including Children Services	60.0%	24.0%	16.0%	84.0%
County-operated Adult Services	37.5%	43.7%	18.7%	81.2%
Contracted Adult Services	50.0%	30.0%	20.0%	80.0%

* Children Services are not regionalized in the study as many relate County-wide.



Chart I

RESULT OF TELEPHONE ACCESSIBILITY
PART II

Outcomes of Ten Attempts to locate Mental Health Assistance by using Directoy Assistance (Dial "411")

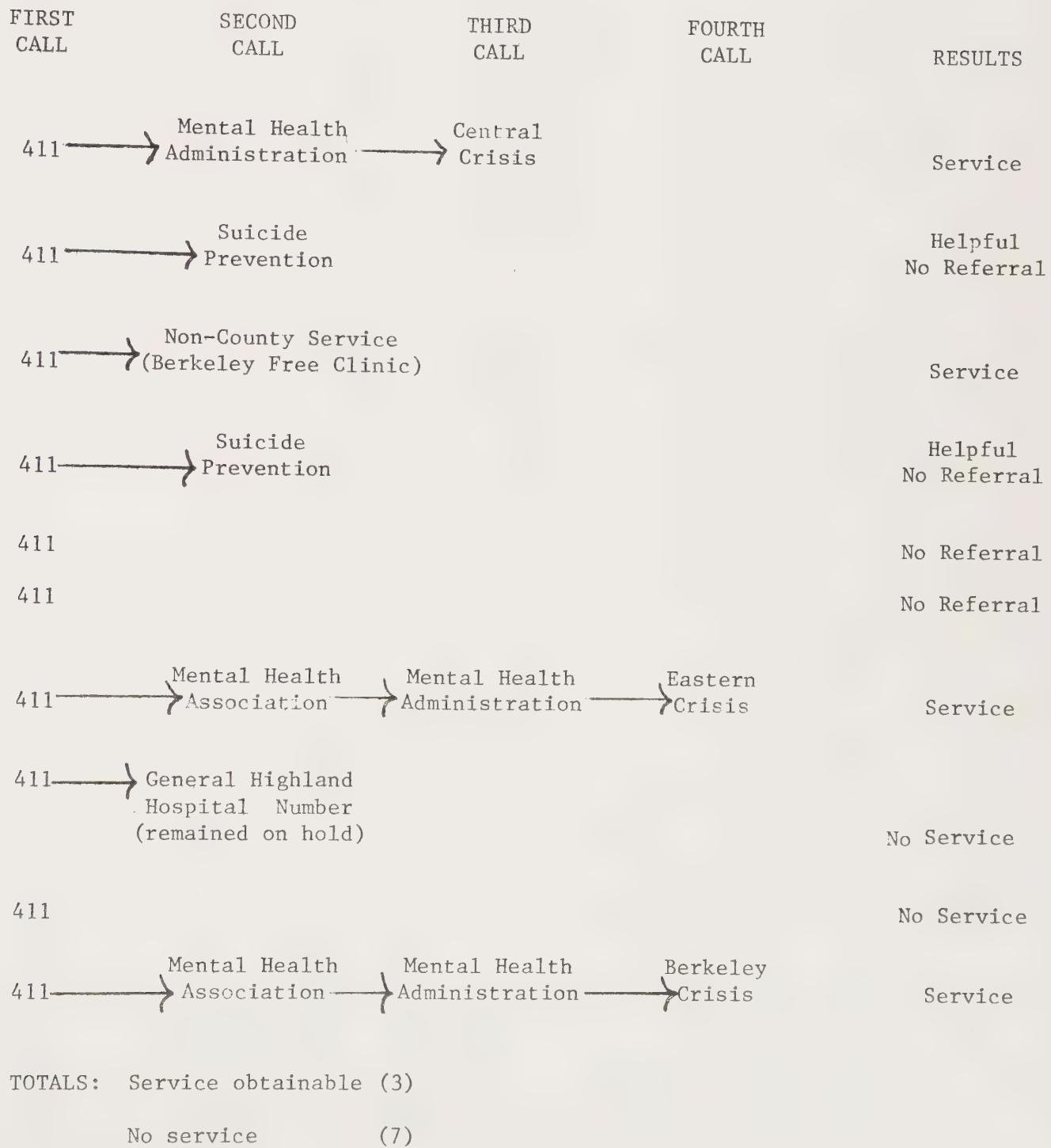




CHART II

RESULTS OF TELEPHONE ACCESSIBILITY (PART II)

Outcomes of Ten Attempts by County Residents to Locate Mental Health Services Using Local Telephone Directories

FIRST LOOKED AT	THEN	THEN	THEN	RESULTS	Totals:
Inside cover	Called Police				No service (9)
Inside cover (not useful)	Looked under "M", - - - M.H. Assoc. -- - called M.H. Assoc.	M.H. Advocates -- referred to M.H. Advocates	4:50 p.m. referred to Berkeley Crisis	No answer at Berkeley Crisis	Limited service (1)
"M" and called - - - M.H. Assoc.	Call made after 5 p.m. no answer				No Service
"M" and called - - - M.H. Assoc.	M.H. Assoc. - - - referred to M.H. Advocates	M.H. Advocates - referred to Eden Crisis	Eden Crisis ad- vised call FPES or Eden Rehab as Clinicians out	- Eden Rehab referred back to Eden Crisis (caller refused)	No Service
Inside cover. "the only number I would have called was the Police, and I'm sure not going to do that.					No service
Caller frustrated because couldn't find a number that seemed right.					No service
Inside cover - - - Called Police.	Police referred to - - "Highland Hosp."	Highland Switch- board referred to Crisis Service	Crisis service said to get there by 4:30, or go to Psych Emergency	- - - - - Limited degree of service	
"M" and called Mental Retardation Service					No service
"M" and called M.H. Assoc. - -	Weekend, no answer				No service
"M" and called H.H. Assoc. - -	After 5:00 p.m., no answer				No service



b) District Residence

WE CONCLUDE that districts (clients' place of residence) are still very much a factor influencing accessibility to services in the screening and referral practices of a majority of County-system programs. This still is the case, despite informal notification by the County Mental Health Director that this is not to be the case.

WE RECOMMEND that a formal, written policy and procedural statement is called for immediately from the Mental Health Director and Regional Directors for distribution to each mental health program, describing in detail the conditions under which district residence may or may not influence admissions in the screening and referral practices of programs.

SUPPORT AND DISCUSSION:

- * Data from November, 1975, survey indicate the following:
 - 73 percent of all clerks surveyed perform screening functions based on guidelines concerning district residence.
 - Only 21 percent of all clinicians and 23 percent of all service chiefs surveyed describe their programs as having no district requirement, or as providing services regardless of problem severity or anticipated length of treatment even if residency were formally required. For the remaining 69 percent of clinicians and 77 percent of service chiefs, service was governed by district residence, with some partial levels of service provided while referral is effected to a program in the clients' district of residence.
 - 28 percent of service chiefs surveyed report clients can receive services if they do not live in the district; 58 percent say yes, under certain conditions; and 14 percent state that district residence is required. Among those programs serving non-district residents at all, 36 percent waive residence if client's job or school is located in the district; 55 percent waive if a therapist relationship was previously established; 17 percent waive if the required service is only available in their program; and 63 percent waive if the client is transient.
- * The Director of Mental Health Service has given informal instructions to Regional Directors within the past few months that district residence should be de-emphasized as a factor affecting admission



to any programs. It is our opinion that in view of several years of rapid expansion and program effort to define clinical operations within a fairly strict district structure, more formal corrective action should be taken. A written statement is called for, specifying the level of consideration which place of residence within the County health districts should be given in admission to programs within the context of a reasonable treatment plan for each client contacting any program for service. There may be some legitimate reasons for programs to select. (See also part d, "Screening Information and Referral Services" below.)

c) Reception Services

WE CONCLUDE that reception services are generally good, both in County-operated and contracted programs.

(No recommendation)

SUPPORT:

- * Survey results indicate no significant differences in self-ratings between County-operated and contract programs.

Overall ratings are:

(Excellent)	(Good)	(Fair)	(Poor)
36%	42%	15%	5%

- * OPE site observation confirm this. See Volume III site analyses which address reception services in program rated poor in staff surveys, by telephone accessibility study and by OPE site observations.



d) Screening, Information and Referral Services

WE CONCLUDE that screening, information and referral services in most mental health programs in the county are primarily inappropriately performed by clerical staff rather than by the clinical staff who are paid and trained to perform them.

WE RECOMMEND that the Mental Health Director, Regional Directors, and other staff designated to perform training functions, prepare a set of guidelines which describe the appropriate roles to be played by clerical and clinical staff in the screening, information and referral process in mental health programs.

We further recommend that after these guidelines are distributed, the Mental Health Director or designated person in the Service's Program Evaluation Unit, conduct a sample telephone survey to ensure that screening, information and referral services are performed appropriately.

SUPPORT:

- * 79 percent of the 67 clerical staff surveyed report that they screen clients - by phone or in person - to find out whether their own program is the one clients should come to for help. The guidelines used for screening are as follows:

<u>Kind of problem the client has.....</u>	76%
<u>Program client needs in the district.....</u>	65%
County residence.....	78%
District residence.....	73%
Financial eligibility.....	39%

(Exceptions: - In six direct treatment programs, clerks do not screen for the kind of problem.
- In eight direct treatment programs clerks do not screen for the district programs needed

- * 63 percent of clerical staff report that they make referrals as part of their average workday. In our questionnaire, clerks were asked only one question regarding presence or absence of clinical



consultation in reference to all the different kinds of referrals made, including telling clients what time they could drop in to the program. Of the 63 percent who make referrals, 33 percent do so with direct consultation from clinicians, and 65 percent do not. In 19 of the direct treatment programs studied, clerical staff refer without clinical consultation. Among these programs, clients are referred, without consultation, to:

by:

- appropriate mental health programs in the district.....12 programs
- other mental health programs.....13 programs
- private therapists.....5 programs
- non-mental health services.....13 programs

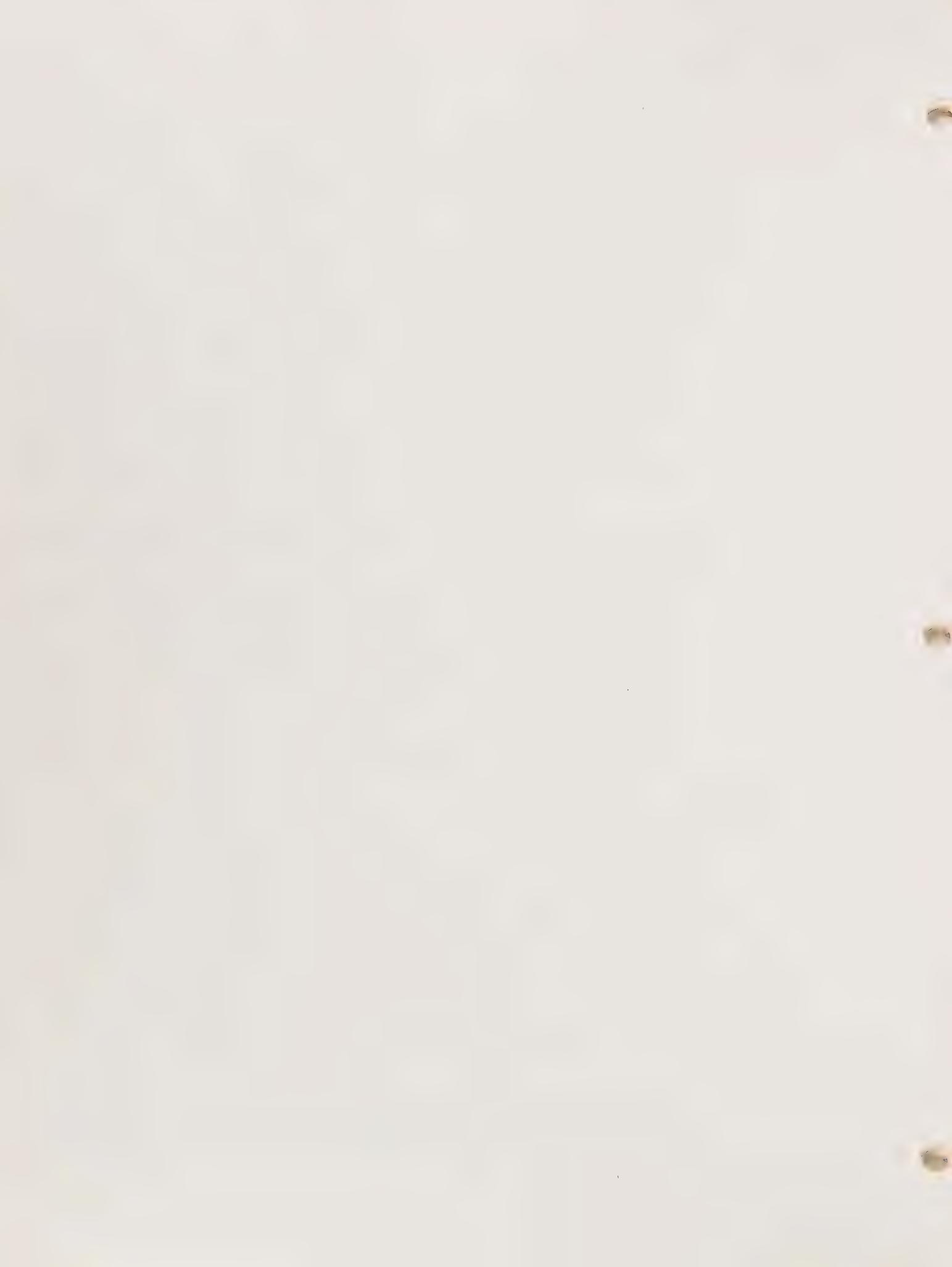
The reasons given by clerks in these programs for making referrals without consultation are:

in:

- clinical staff clearly expects this as part of the job. 6 programs
- clerical staff enjoy helping people by knowing where to refer people.....9 programs
- clinicians don't have the time.....4 programs
- clinicians don't take the time.....1 program

SUPPORT:

- * Telephone accessibility study showed that in 96% of programs called, clerical staff consistently performed screening and referral functions without either consulting with a clinician or asking callers if they wished to speak to someone else. The only clerical staff to ask callers if they wanted to talk with a clinician were those at Lincoln Child Center and East Bay Activity Center.
- * In highlighting this issue, we believe that clinicians and administrators as a group have relegated two major clinical functions to clerical staff.



It is our belief that screening functions may legitimately involve clerical staff, but never in screening for the kind of problem clients have or the program clients need. The solution here is for clinical and clerical roles to be clearly defined in each program. Reliable direction and training of clerical staff is required to ensure that clients are offered the opportunity to speak with a clinician, no matter what the apparent question is. Obviously, clinicians need to be available to be consulted.

We question the appropriateness of clerical staff making referrals under any conditions, except as a prescribed duty relating to financial liability, such as advising clients on how to apply for Medi-Cal or in completing liability determinations, after the client has spoken with a clinician. We question the practice of clerks making referrals with clinician consultation because it involves telephone delay and indirect communication which does violence to the sensitivity of the referral process.

Our productivity studies would not support the conclusion that clerical staff perform so many screening and referral functions because clinicians are overworked.

Considering the number of factors involved when a client contacts a program for service, we feel it would be advisable for Mental Health Administration to describe which staff are to provide what kinds of screening and referral for what kind of client contact, i.e., telephone information, drop-in to clerical station, clinical screening interview, etc.



e) Location, Accessibility by Public Transportation, and Physical Visibility

WE CONCLUDE that the locations of all out-patient programs at Highland Hospital are inappropriate because they are difficult to find within the hospital complex. Additionally, East Oakland Crisis is difficult for East Oakland residents to reach by public transportation.

WE RECOMMEND that Central Crisis, Central Rehab and Central Day Treatment be relocated together or in close proximity at a visible site in the Central district area.

WE RECOMMEND that East Oakland Crisis be re-located in a visible location in East Oakland. accessible to public transportation.

We further suggest that the site for Crisis be located toward the southern end of the health district as East Oakland Rehab is now located in the Fruitvale area, and that shared staffing arrangements be considered subsequent to relocating in order to provide both crisis and rehabilitation services in each site.

SUPPORT:

- * The percentages of clinical staff who feel that present locations at Highland Hospital are not appropriate are:

Central Crisis.....83%

Central Rehab.....71%

Central Day Treatment.....50%

East Oakland Crisis.....94%

- * OPE site evaluations confirm these opinions.

- * 35% of East Oakland Crisis staff feel that accessibility to the program by public transportation is rather difficult, and 6 percent that the program is not accessible.

- * OPE site evaluations confirm this opinion.

- * See Program Design below for further discussion of crisis and rehabilitation programs generally.



WE CONCLUDE that Highland Psychiatric Emergency's location within Highland Hospital is not appropriate because it is difficult to find within the building and its space is grossly inadequate to serve the needs of the program.

WE RECOMMEND that Highland Psychiatric Emergency be relocated to Wing D-2 at Highland Hospital, with consideration given to retaining the F-basement location for its accessibility to ambulance services and as a second reception area, if necessary.

SUPPORT:

42% of clinical staff responding to survey feel the location of the program is not appropriate. Most staff have supported a proposal to move from F-basement to Wing D-2 within Highland Hospital in order to improve program operations generally and broaden the range of services and functions it can serve.

OPE site evaluations strongly confirm these opinions. However, the D-2 location, though closer to the inpatient units, presents considerable difficulty in access by the public, and is some distance from ambulance entrances. Removal of East Oakland Crisis from Wing D-3 would allow consideration of this space which fronts the hospital's medical emergency entrances.

WE CONCLUDE that the locations of all outpatient programs at Fairmont Hospital are inappropriate because they are difficult to find on the hospital campus. Additionally, the sites of Eden Crisis and Eden Day Treatment are grossly unsuited to the program operations of each.

WE RECOMMEND that these outpatient programs be relocated together or in near proximity at a visible site somewhere in the communities they serve.

SUPPORT:

- * 83% of Eden Day Treatment clinical staff feel the location is not appropriate. 100% of Day Treatment and Crisis staff feel that finding the site is sometimes or quite often a problem. 60% of Eden Children's Service feel that finding the program is sometimes a problem.



*See also site analyses for these in Volume III.

*Observations of our evaluation team support these opinions.

WE CONCLUDE that Eden Rehab's location in the Southland shopping center is inappropriate because it is difficult to reach by public transportation and it is not easy to find either in the large shopping complex or within the building.

WE RECOMMEND that Eden Rehab be relocated to a visible site that is accessible by public transportation, preferably together with or in close proximity to Eden Crisis and Eden Day Treatment programs.

SUPPORT:

- * 60 percent of program staff feel that finding the program is either quite often or sometimes a problems for clients. 60 percent feel the location is inappropriate; and 40 percent state that accessibility to the program by public transportation is rather difficult.

*See site analysisis for this program in Volume III.

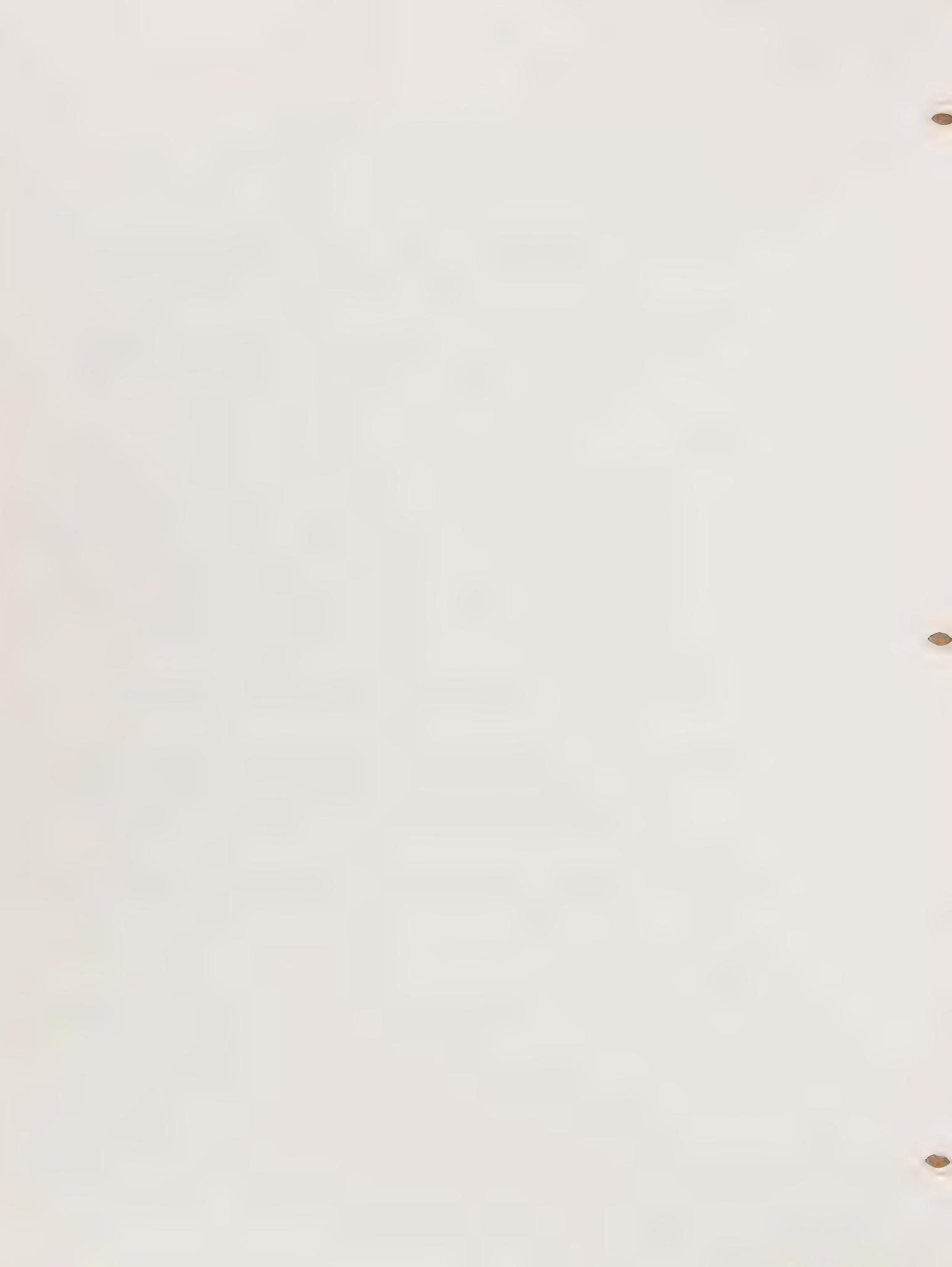
*Observations of the evaluation team support these opinions.

WE CONCLUDE that the location of the three Valley programs (Crisis, Rehab and Childrens) is inappropriate because access by public transportation is very difficult, and finding the site within the shopping complex and within the building is not easy for many people.

WE RECOMMEND that the Valley programs be relocated in a visible site which is accessible by the limited public transportation available in the area.

SUPPORT:

- * 100 percent of Valley Rehab staff feel the location is not appropriate. The great majority of all three program staffs state that accessibility by public transportation is either rather difficult or that the site is not accessible at all. 45 percent of all three program staffs state that finding the site is quite often a problem and 45 percent state it is sometimes a problem.



*See also site analyses for these programs in Volume III.

*Observation of the evaluation team support these opinions.

WE CONCLUDE that Berkeley Crisis Intervention Service is not located appropriately from the standpoints of ready identifiability in the community or of full-time accessibility by public transportation.

WE RECOMMEND that this program should be relocated to an identifiable community site more accessible to public transportation. However, relocation is complicated by several other factors including the value of contiguity with the Adult Outpatient program and the resolution of Berkeley's need for a local inpatient or subacute facility. Our recommendation is therefore, contingent on the resolution of these other issues.

SUPPORT:

- * 60 percent of Berkeley Crisis clinical staff feel the program's location is not appropriate. 40 percent state that access the site by public transportation is rather difficult.

*See also site analysis in Volume III.

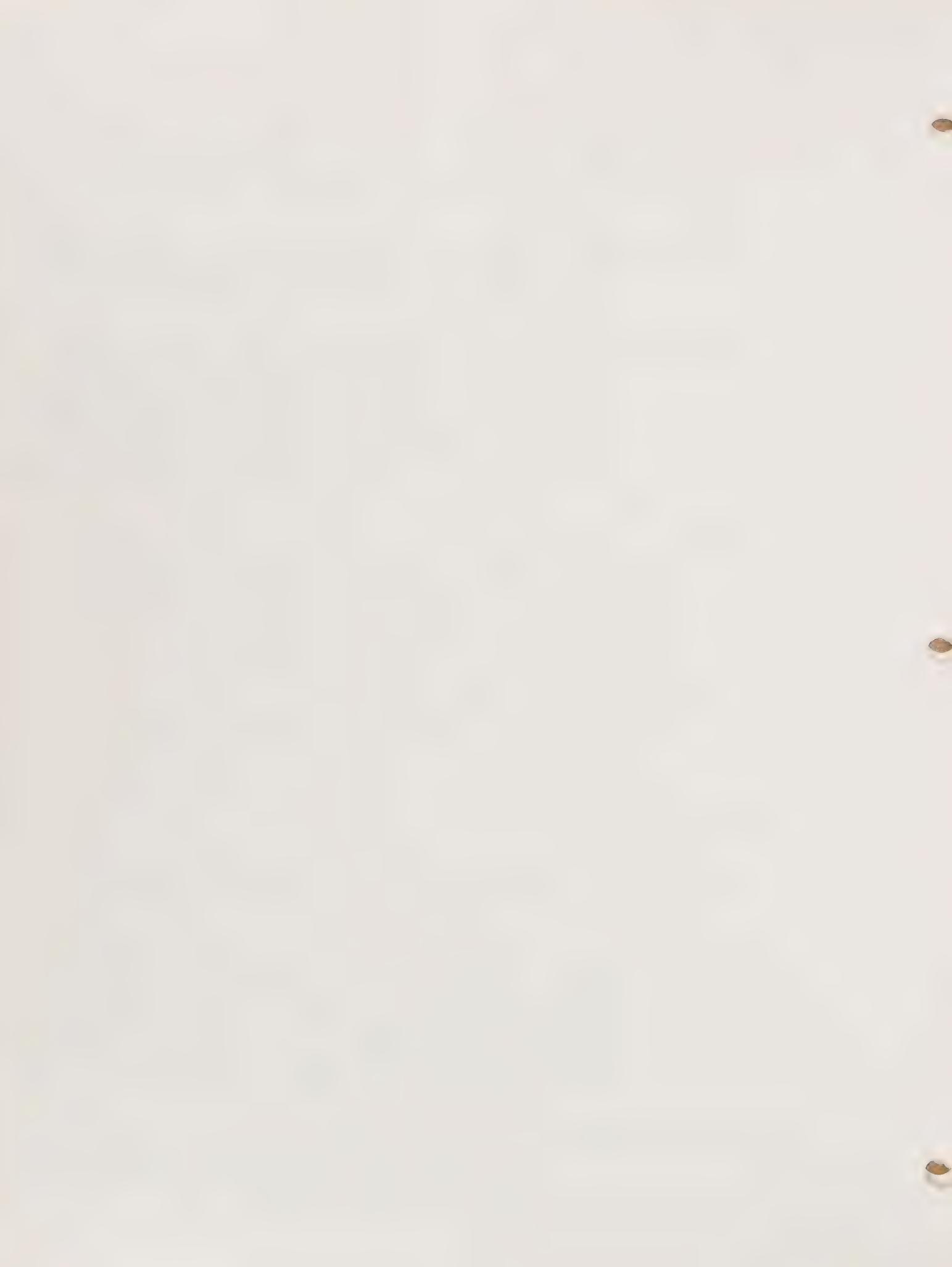
*Observation of the evaluation team support these opinions.

f) Hours of Operation

WE CONCLUDE that the hours of operation of all crisis programs are inadequate because they are not open on the bases of peak hours of need seven days a week.

WE RECOMMEND that the need for crisis programs to serve seven-day-a-week needs be closely assessed by a survey of requests in Crisis programs for evening hours of service; by a survey at psych emergency services to determine the peak hours in which psych emergency sees clients who can more appropriately be serviced on an outpatient, drop-in bases; and also by a survey of municipal police departments to determine the need for crisis intervention services.

We further recommend that if these surveys indicate the need for extending the hours of crisis programs, that the program designs for crisis and psychiatric emergency programs be altered to meet the needs.

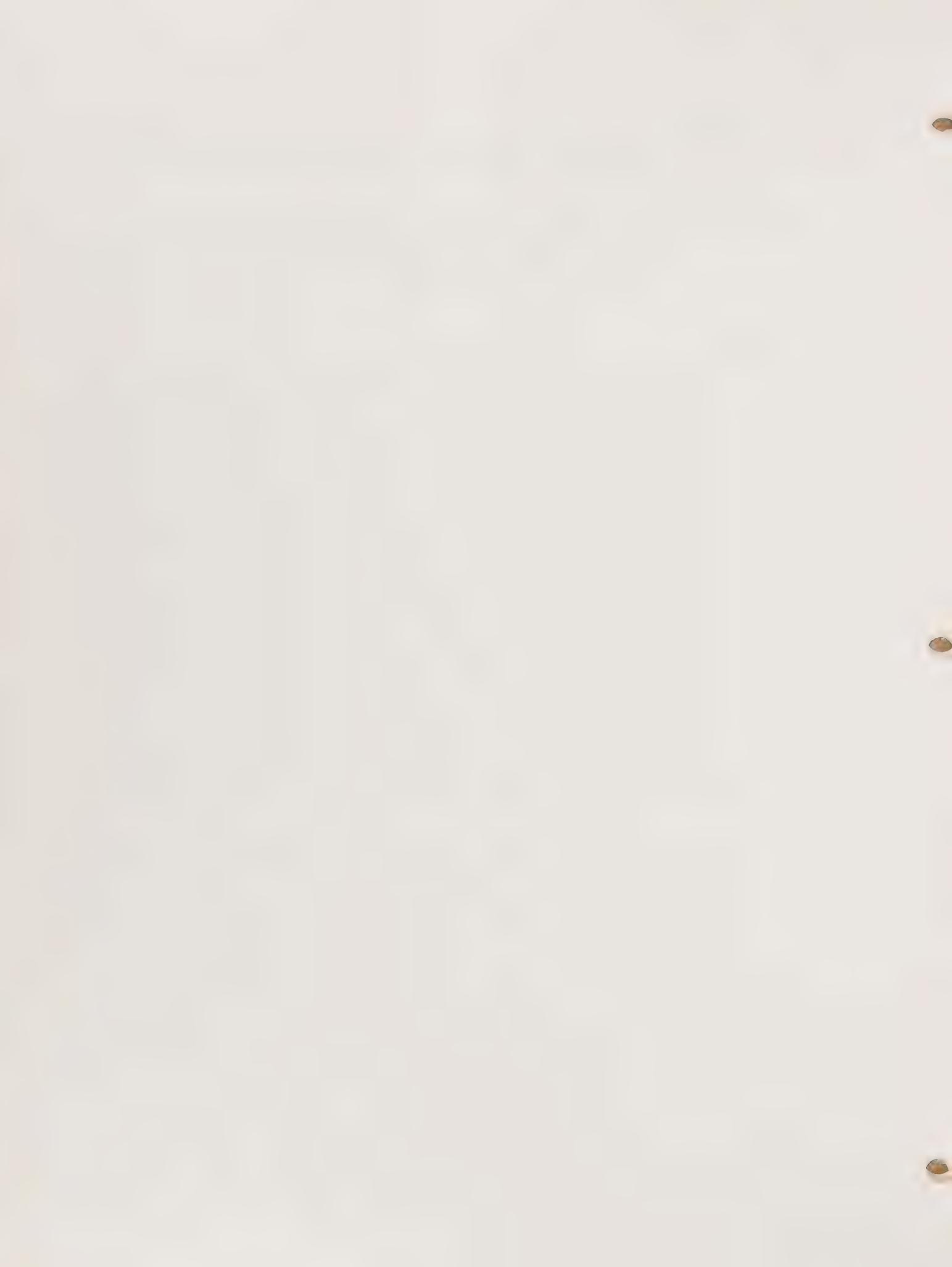


WE CONCLUDE that rehabilitation and children's outpatient programs have a need for increased hours both in the evening and on weekends.

WE RECOMMEND that surveys should be conducted regularly of requests for evening and weekend service in these programs, and service chiefs should arrange staff hours (on an equitable basis) to meet these needs.

SUPPORT:

- * "Crisis" programs hours are between 8 - 5 p.m. weekdays to see drop-in clients, excepting Berkeley Crisis which is open until 10:30 p.m. on weekdays only. All programs rely on Highland and Fairmont Psychiatric Emergency Services to serve 24 hours needs. No assessments have been formally made to study which kinds of clients seen at psych emergency during which hours could better be served by crisis programs. No formal surveys have been made of municipal police departments in the North Region to determine the need for mental health crisis intervention services. Few outpatient programs reporting need for extended hours have conducted their own interval studies to exactly determine need.
- * Most staff in four Rehab programs, two crisis programs, four children's programs (including PGC) and one psychiatric emergency believe that the hours of program operation are not adequate to meet the needs of their clients. In the children's and rehab programs staff believe that there is a need for evening hours; in the crisis programs and PGC, staff believe there is also a need for weekend hours of operation.
- * One-stop centers in the community, staffed by combinations of rehab, children's and crisis program staff would increase program



capacity to remain open and provide more services generally.

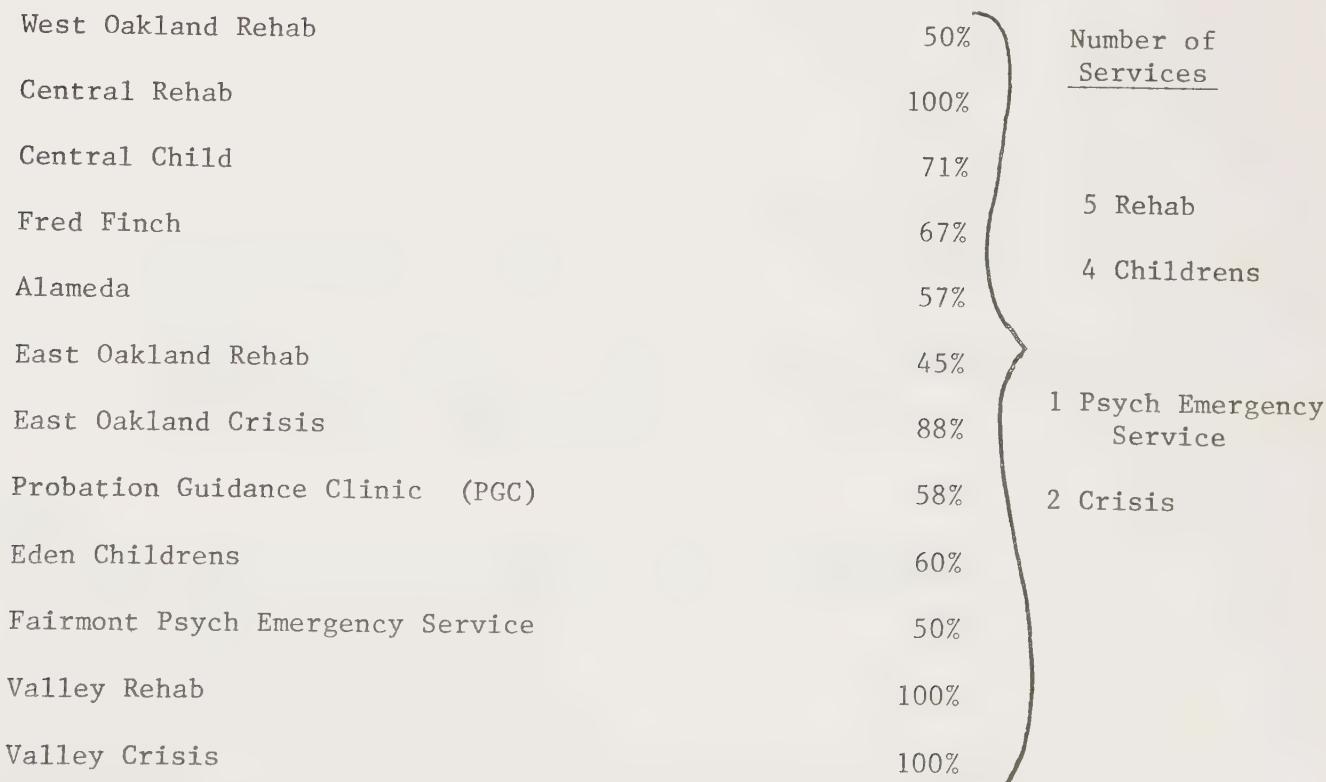
* The following survey results are based on answers to the question:
"Are the hours of your program adequate to meet the needs of your clients?"

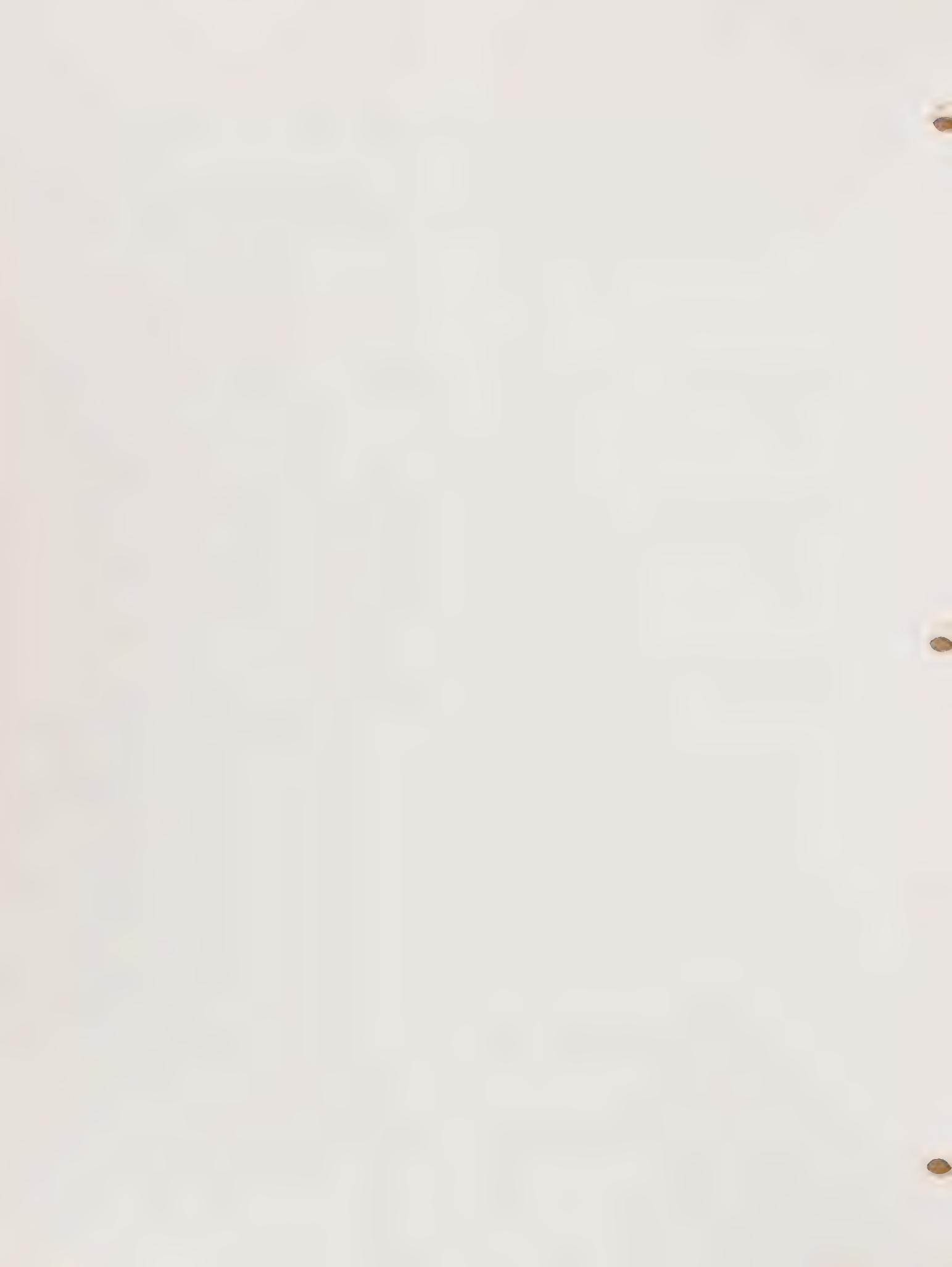
by <u>Clinicians</u>	<u>COUNTY</u>	<u>CONTRACT</u>	<u>TOTAL</u>
YES	57%	80%	65%
NO	41%	17%	33%

by <u>Service Chiefs</u>	<u>COUNTY</u>	<u>CONTRACT</u>	<u>TOTAL</u>
YES	12/63%	13/77%	25/69%
NO	7/37%	4/24%	11/31%

by Program (Clinician Survey)

(Percentage of "NO" responses)





WE CONCLUDE that psychiatric service at Fairmont Psych Emergency Services between 11:00 p.m. and 8:30 a.m. is a makeshift operation. Lack of psychiatric staff coverage affects accessibility to the degree that client requesting service in person or by telephone must be re-referred to HPES that night or return to EPES the following day. Clients may be kept overnight in the program under a physician's direction with telephone consultation to mental health staff.

WE RECOMMEND that further review be made of utilization, by requests for service between 11:00 p.m. - 8:30 a.m. in person and by telephone as well as by the actual number of cases seen, and additional staff should be provided to meet the needs of the South County region of 24-hour emergency care.

SUPPORT:

Staff interviews and surveys indicate strong feelings that 24 hour psychiatric emergency care is required.

Review of EPES log for the month of November, 1975, shows 64 persons admitted to the program at or after 11:00 p.m. and not provided psychiatric treatment until 8:30 a.m. the following day. This log does not include telephone calls or persons turned away at the desk who are told no psychiatric staff are on duty.

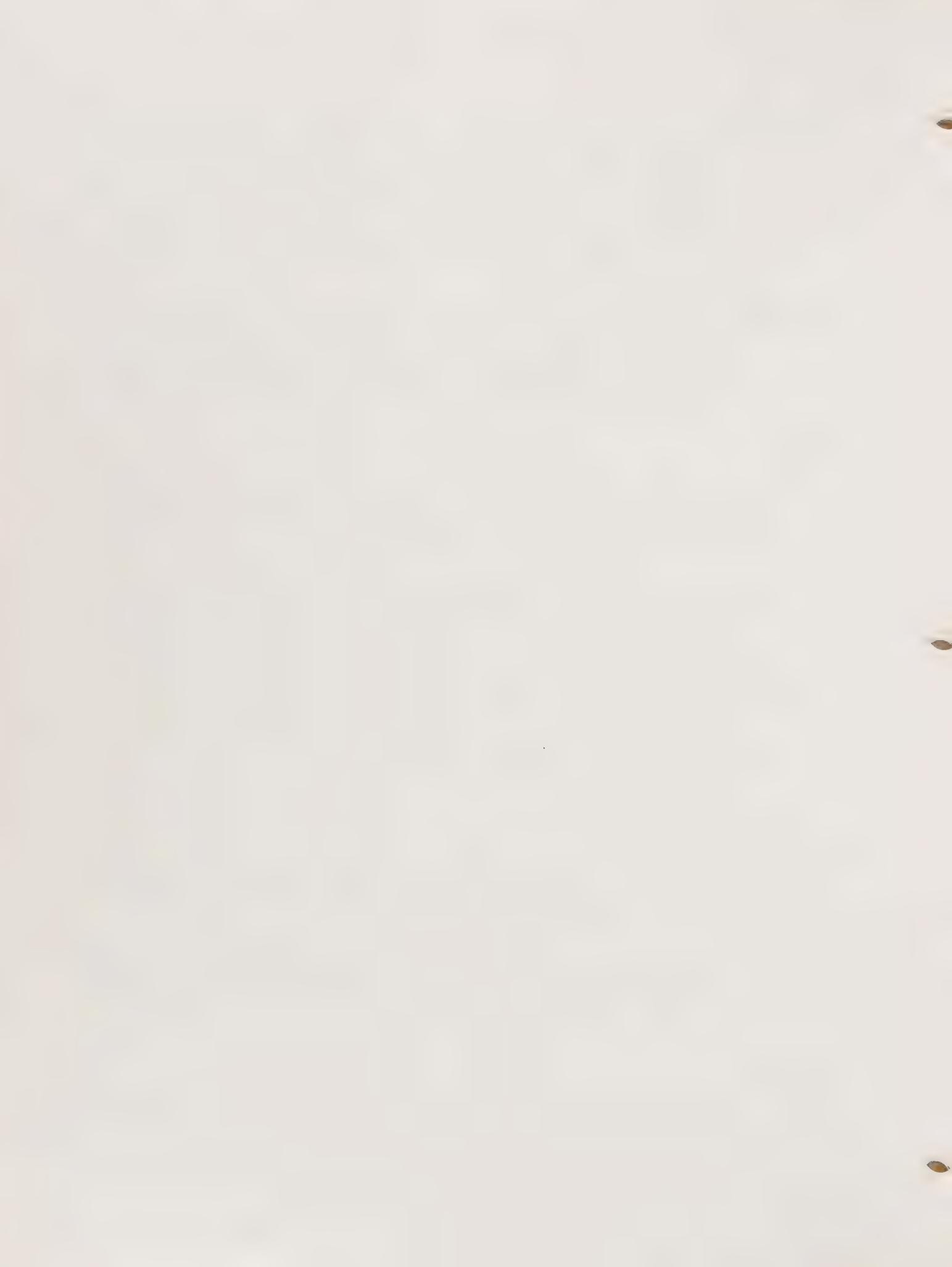
g) Cultural or Racial Access and Welcome

WE CONCLUDE that the issues of cultural and racial accessibility have been inadequately studied by Alameda County Mental Health Services Planning Units.

WE RECOMMEND that these Planning Unity conduct a detailed and complete needs assessment of cultural and racial accessibility to all mental health programs in both regions of the County.

SUPPORT:

Insufficient data was available to this evaluation from the County upon which to base a thorough analysis of this factor of accessibility.



Since needs assessments were not seen as the purpose of OPE evaluation, conclusions and recommendations which follow are based only on data available to our evaluation.

WE CONCLUDE that barriers to accessibility on the basis of cultural or racial influences are readily apparent, based on available data. Both Asians and American Indians appear to be underserved.

Spanish-speaking persons appear to be underserved by some programs.

WE RECOMMEND that Alameda County vigorously pursue its Affirmative Action policy in such a way as to staff all mental health programs in proportions at least equal to percentages of cultural and racial groups served by those programs, and require the same of contract programs.

WE CONCLUDE that the contracting of mental health services to private community groups which are explicitly asked to serve particular segments of the community is a positive practice, especially from the standpoint of cultural and racial accessibility.

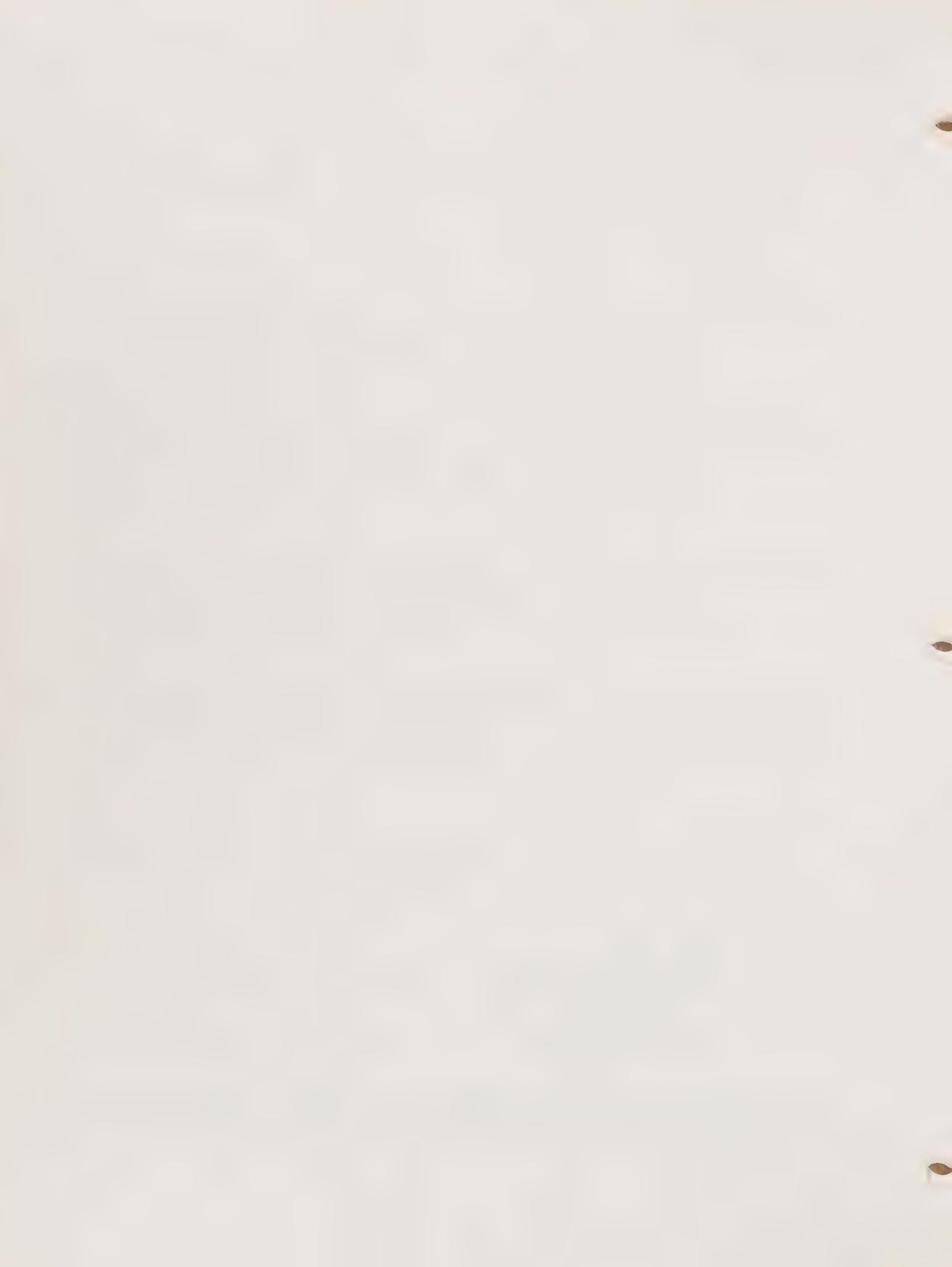
We further recommend that Alameda County Mental Health Service continue its practice of contracting mental health programs to private groups demonstrating concern and ability to work with underserved cultural and racial groups, giving priority to programs already serving Asian and American Indian groups.

SUPPORT:

Survey data on open caseloads from treatment impact study reveal the following distribution on ethnic backgrounds:

58.1%	Caucasian	
28.4%	Black	Varies widely, program to program
10.1%	Spanish surname	
1.3%	Asian	
.3%	American Indian	Appear to be clearly underserved
1.1%	Polynesian	
.6%	missing data	

* See Section V, Financial and Administrative Support, describing slowness of implementation in mental health programs of County Affirmative Action Policy.



- * Partly through the existence of NIMH grant to East Oakland Community Mental Health Center as added to Revenue Sharing, increased funding has been possible for El Centro de Salud Mental, East Oakland Family Health Center, and as prioritized by North Region, to Asian Community Mental Health Services and to Intertribal Friendship House, if plans are realized.
- * Surveys of clinicians reveal that only 3.2 percent report that client complain often about language or cultural barriers, but 45.5% report clients complain occasionally. Similarly, clerical staff respond as follows: 8.8 percent report clients complain often, and 35.5 percent that client complain sometimes.
- * Service chiefs rate their clinical staffs' competence in relating to third-world clientele as follows:

	(Excellent)	(Good)	(Fair)	(Poor)
County Programs	26%	58%	11%	5%
Contract Programs	75%	19%	6%	0%
TOTALS	49%	40%	9%	3%

h) Language Accessibility

WE CONCLUDE that Spanish is the only language widely available in mental health programs and that this is absent in several programs serving geographical areas with many Spanish-speaking citizens.

WE RECOMMEND that Alameda County promote the hiring of Spanish-speaking staff as the first priority for hiring in those programs serving geographical areas with substantial Spanish-speaking citizens, which have no such staff at present and that Alameda County require the same of contract programs.

We further recommend that the mental health services planning units determine which programs should be serving clients speaking a variety of Asian languages and convey similar hiring priorities to mental health administration.



- * Staff surveys describe the programs' self-estimates of adequacy in serving people who are limited in English language:

	<u>CLINICIANS</u>		<u>SERVICE CHIEFS</u>	
	YES	NO	YES	NO
Contract	60%	36%	71%	29%
County	53%	44%	35%	65%
TOTAL	55%	41%	53%	47%

- * The following capacity of programs to serve Spanish-speaking and Asian clients, especially, is described in our survey of service chiefs.

*Survey of Service Chiefs, which provides the following breakdown of languages available

(Program/Percentage of Programs)

	<u>Contract</u>	<u>County</u>	<u>Total</u>
Japanese	4/24%	1/5%	5/14%
Chinese:			
Mandarin	4/24%	0	4/11%
Cantonese	5/29%	2/11%	7/19%
Vietnamese	2/12%	0	2/6%
French	3/18%	4/21%	7/19%
Tajalog or Philipino	3/18%	2/11%	5/14%
Spanish	12/71%	11/58%	23/64%
Portugese	1/6%	1/5%	2/6%
Other	2/12%	3/16%	5/14%



WE CONCLUDE that Alameda County Mental Health Services has only limited contacts for translation services to serve non English-speaking clients, specifically lacking a central directory of County mental health staffs' foreign language capabilities.

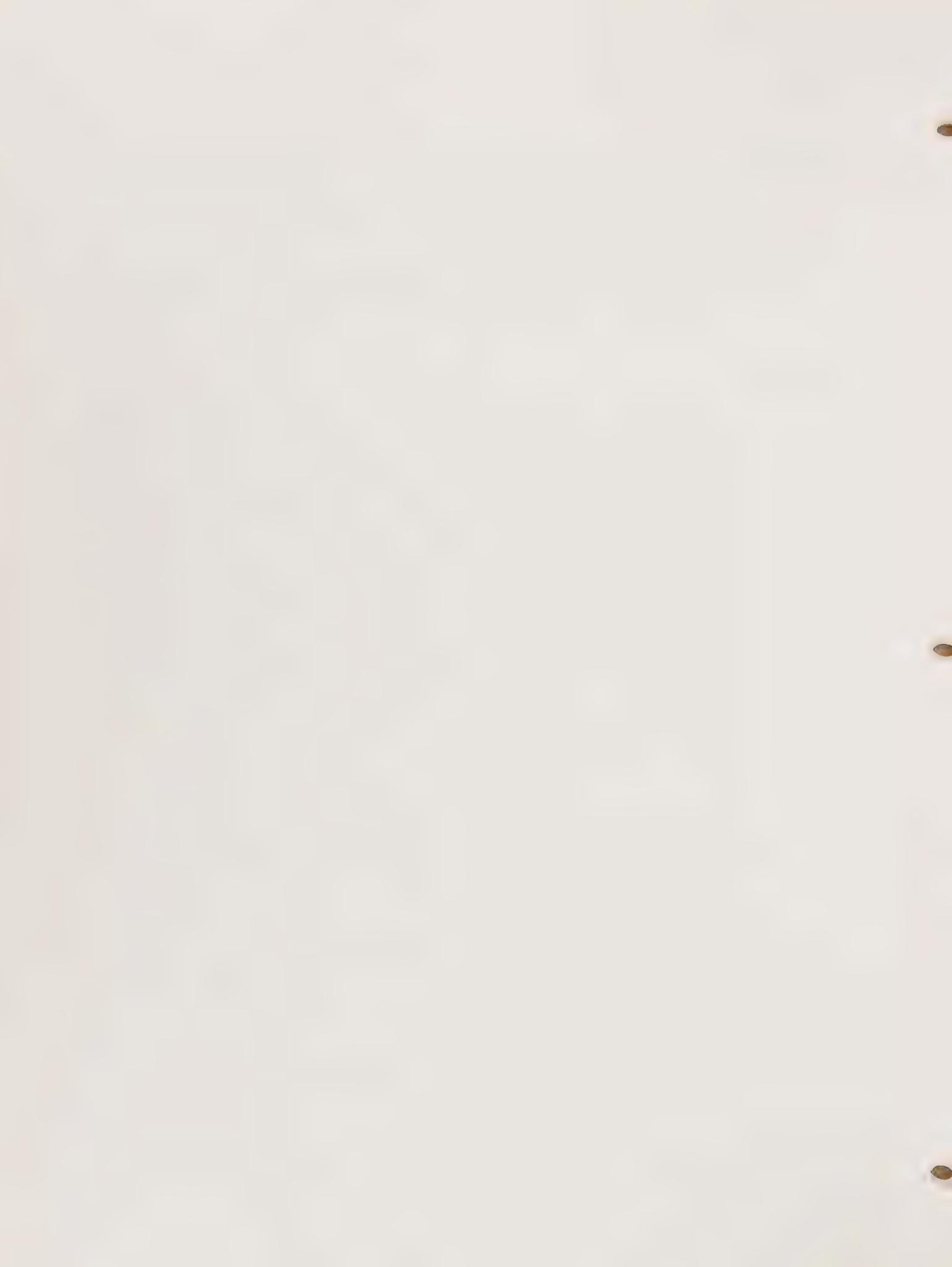
WE RECOMMEND that Alameda County compile a central resource directory of its own staffs' foreign language speaking capabilities to draw upon in serving the clients in all County Mental Health Programs.

SUPPORT:

- * Apparently the only central contacts for County programs to obtain translation services are the Asian Community Mental Health Services and the International Institute which works with Asian immigrants. There is no central file of mental health staff on the County, such as exists, for instance, in the Probation Department, to provide translating services for all foreign languages in which the staff has some capability. Comprehensive translating services, though far short of meeting the needs of ongoing psychotherapy, are certainly a place to begin.
- * Survey of service chiefs asks whether there exists a resource directory or central contact in the County available to one's program for obtaining translating services:

	(COUNTRY)	(CONTRACT)	(TOTAL)
YES	9/50%	6/37.5%	15/44%
NO	9/50%	10/62.5%	19/56%

(respondents/percentage of total number)



i) Capability to Serve Physically Handicapped

WE CONCLUDE that Alameda County Mental Health services to the blind, deaf and paraplegic are probably inadequate, with the needs of deaf citizens seen by the mental health staff as least adequately met.

WE RECOMMEND that the Mental Health Director appoint a working committee from those program staff members more familiar with the special mental health needs to the blind, deaf, paraplegic and partially-sighted to make more specific recommendations for meeting these needs. Our data and interviews suggests that the needs of the deaf should receive first priority.

SUPPORT:

- * Staff surveys provide program self-estimates of adequacy in serving people who are:

	(CLINICIANS)		(SERVICE CHIEFS)	
	YES	NO	YES	NO
BLIND	50%	47%	50%	50%
DEAF	23%	74%	21%	79%
PARAPLEGIC	43%	52%	53%	47%
PARTIALLY-SIGHTED	75%	21%	91%	9%

- * Surveys describe the frequency of clients complaining about physical barriers (steps or stairways) in their programs as reported by:

	(OFTEN)	(SOMETIMES)	(NEVER)
CLINICIANS	10%	20%	64%
CLERKS	10%	18%	65%



j) A Procedural Impediment

WE CONCLUDE that the current admission forms containing the Medical and Surgical Consent paragraph are inappropriate for the provision of mental health services in County-operated programs.

WE RECOMMEND that the County Mental Health Service prepare a new consent for treatment form which omits the Medical and Surgical Consent paragraph entirely.

SUPPORT:

- * The currently used Admission Records (forms numbers 300BE2 and/or 313BA9) used in County) used in County-operated mental health programs includes a paragraph which reads:

MEDICAL AND SURGICAL CONSENT

I hereby give permission for any medical or surgical treatment and diagnostic procedures, including x-ray examinations, laboratory procedures, injections, blood transfusions, anesthetics, operations, removal of tissue and disposal of tissue or other hospital services rendered to me as a patient and under the general and special instructions of physicians performing professional services within the system of the Alameda County Health Care Services Agency.

- * This form is simply the same one used in Medical Institutions for medical admissions, and is not at all sensitive to the admission procedures for psychiatric outpatients. When and if clients on the inpatient psychiatric unit require medical/surgical treatment, they can easily be asked to sign this medical authorization form in its proper context.
- * In order to cope with clients' reactions to being asked to sign this form a variety of measures are used by mental health clerks to clarify and modify chart-opening procedures, including scratching out the offending paragraph, not requesting a signature at all on the form, making apologies, etc. Survey data for clerical staff report the frequency with which clients object to signing this form:
 - often..... 21%
 - sometimes..... 35%
 - rarely..... 16%
 - never..... 2%
 - don't know..... 19% (not all clerical staff perform reception and chart-opening duties)



2. PROGRAM DESIGN

This section addresses the several elements comprising a large system for delivery of mental health services. It speaks to the questions of the range of services delivered, how services are designed and the capabilities of the staff who deliver them, in respective programs, in the larger network of publicly-funded mental health services.

a) Type of Problem Served

WE CONCLUDE that the present structure of district services, designed both on the basis of the type of client problem served and the kinds of services offered, is in itself as impediment to accessibility. Excessive division of services is confusing, the problem labels misleading, and the chances for losing clients in a bureaucratic screening and referral process are increased considerably.

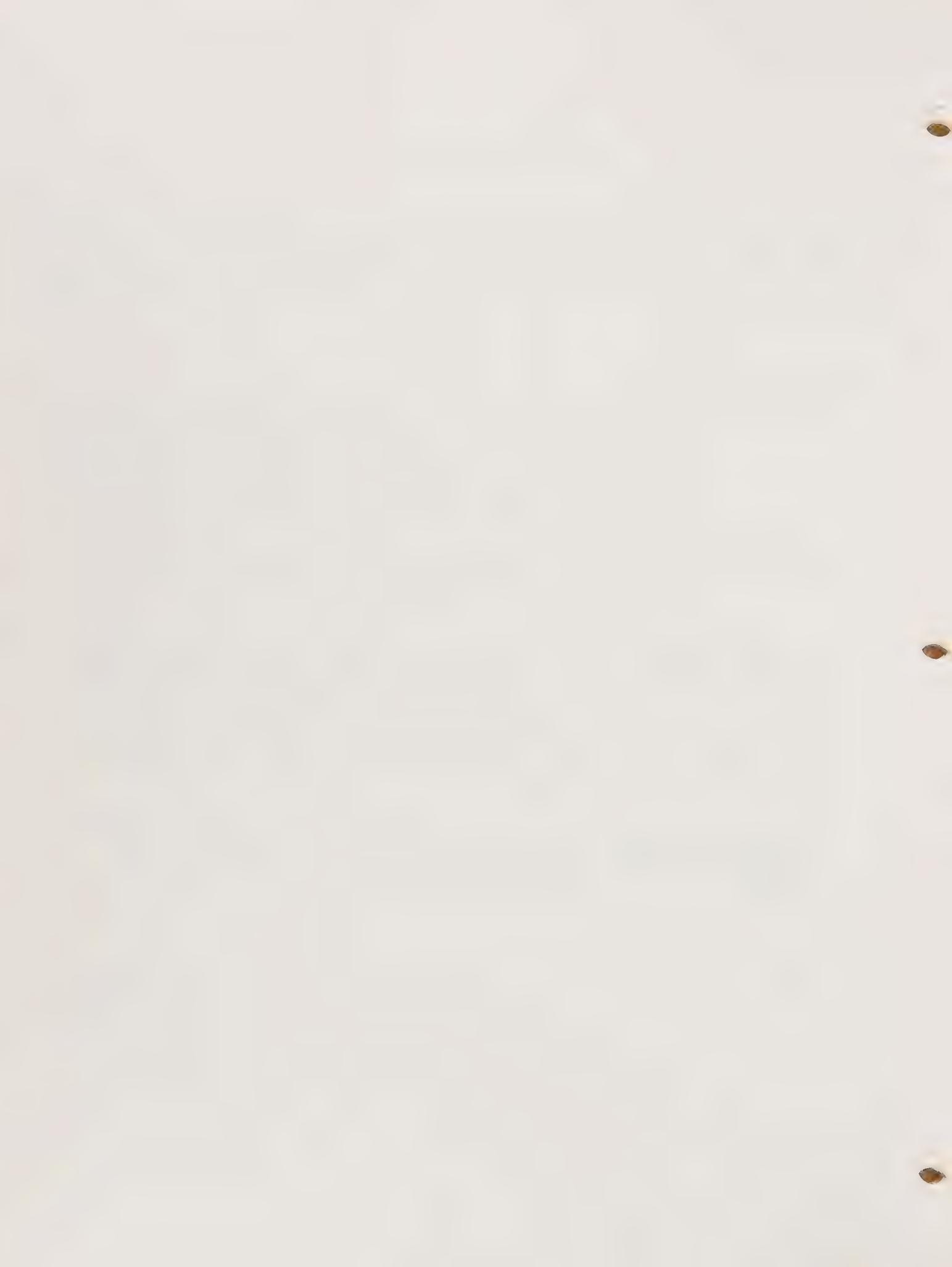
WE RECOMMEND that within each County region, services be designed around local "centers" with high community visibility, recognized as the places to go for any mental health services.

WE FURTHER RECOMMEND that programs presently arrayed into modalities within the present semi-functional "district" design move toward combining their service delivery systems into local "centers" through a progressive application of liaison work, joint working agreements between programs, regular attendance at one another's meetings, and finally, shared staffing arrangements. Through each stage of this transition, attention should be paid to issues of continuity of care, and how a client is to be served, rather than who is to serve the client.

WE FURTHER RECOMMEND that regional clinical directors personally facilitate and review this transitional process, with concise decisions about the permanent new "lines of authority" taking place after each "center" is considered to be working in its more final form.

SUPPORT:

- * Staff survey of 310 clinicians asked to "rate the overall design of the complete range of community mental health services as performed by programs in your region of the County" provides the following responses:



	COUNTY	CONTRACT	TOTAL
- design makes sense; clients get what they need; transfers easy to make	22%	24%	23%
- design has serious deficiencies; clients have trouble finding the right program	17%	18%	18%
- design probably adequate for many; some problems of definition; programs bicker where client should be seen	18%	29%	25%
- design has too many gaps in it to serve all the clients it should	20%	22%	21%

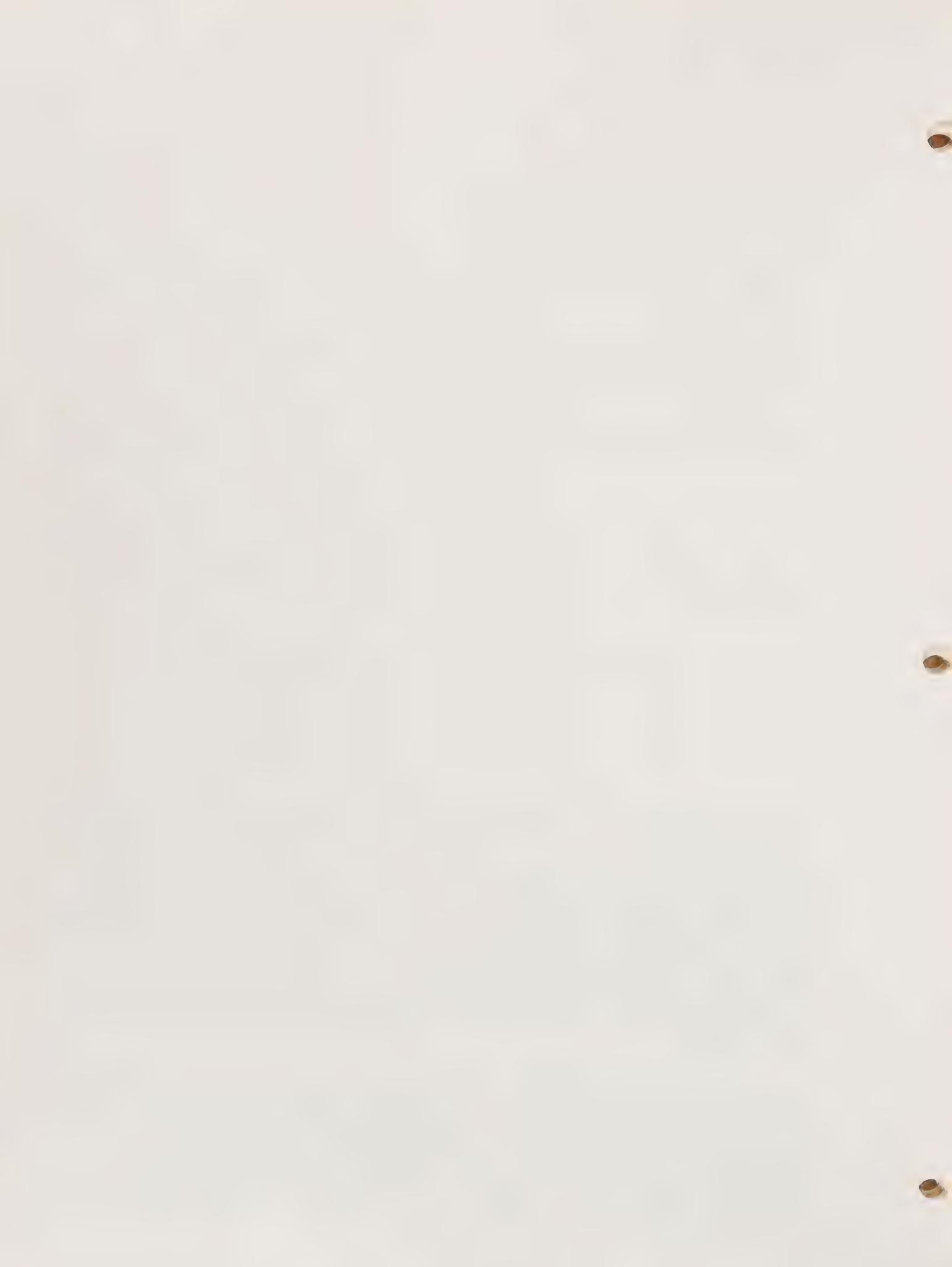
* Survey question asks, "Do you think the name of your program is appropriate?"

Responses are:

	CLINICIANS			SERVICE CHIEFS		
	County	Contract	Total	County	Contract	Total
YES	77%	86%	80%	14/74%	15/82%	29/81%
NO	22%	14%	19%	5/26%	2/12%	7/19%

Contract programs are dissatisfied with the non-generic names of their founders; County-operated programs are dissatisfied in a more fundamental way by misnomers as modalities. Five children's programs, two Rehab programs and one Crisis program are identified. The appellation "Child Development" signifies little relative to the counseling and psychotherapy of children and their families, and makes visibility difficult. "Rehabilitation" signifies little about supportive social and clinical services for clients who have been hospitalized repeatedly, and is easily confused with State Vocational Rehabilitation programs, so that new clients are frequently disappointed to learn they have not enrolled in job training. And "Crisis" is an unnecessarily dramatic title for a program serving a variety of out-patient needs.

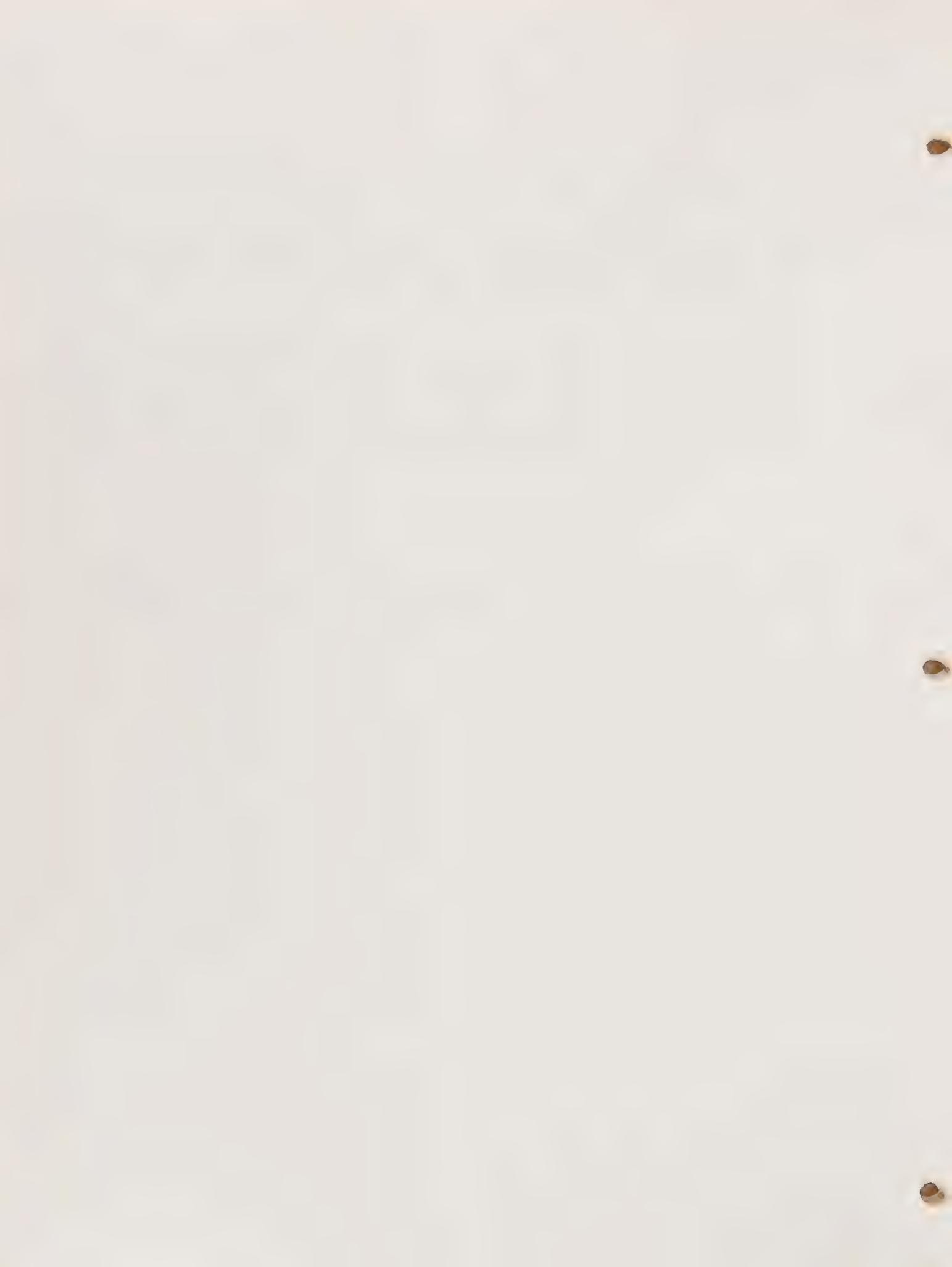
When these names were devised, so also were the functional and geographic distinctions between programs. This process occurred much too hastily and arbitrarily when all programs in Health Care Services Agency went through one of their periodic staff reorganizations into health districts, with administrative overlay between mental health, public health, medical institutions, and substance abuse services. Mental health services were rapidly, in a year's time, without adequate direct control or review by Mental Health Administration.



One basis for distinguishing modalities was the then-available SRS funding for Rehab programs which in Alameda County were apparently believed to have to be organizationally separate from other outpatient programs. The State LPS law specifies only that various capabilities be available, not that each modality be separate and distinct from others. The present divisions are, in fact, counter to the spirit of LPS with its concern for the development of a community mental health model.

Staffing patterns for Rehab and Day Treatment were derived from a model containing a "representative" number of personnel classifications included in the Inpatient Service. As programs later defined their operations more closely, many positions had to be reclassified. Our services indicates that 74 percent of all service chiefs report it has been necessary to re-classify positions; our interviews disclose reclassification problems to be live issues in many Rehab and Day Treatment programs.

* See the remainder of this section for detailed examples of problems created by these divisions of services.



b) Variety of Services Available by "Modality"

Crisis Intervention Services

WE CONCLUDE that most "crisis" programs in the mental health system provide an inadequate range of either crisis intervention or adult outpatient services, and confusion between the two exists at the line program level because the necessary distinctions among the full range of needed adult services were never made by mental health administration.

WE FURTHER CONCLUDE that crisis program with relatively small staffs and no complementary adult outpatient programs in their district, are not capable of serving both crisis intervention and adult outpatient functions.

WE RECOMMEND that the Mental Health Director explicitly define the range of adult outpatient services to be included in mental health programs; and that Regional Directors develop program designs which allow for judicious inclusion of crisis intervention, long and short-term outpatient treatment for children, adults and families, and day treatment and rehabilitation services within a "center" model.

Site analyses of crisis programs (Volume III) reveal an inadequate range of services in most programs, reflected for the most part by only fair or poor self-ratings of group and family therapy, and advocacy and residential placement services. In general, adult outpatient services beyond the one-to one (client to therapist) crisis intervention level do not appear to be well-developed in any crisis program. The need for diversity and depth of services for clients once involved in therapy naturally creates a tension between this need and meeting emergency needs of new clients. To some extent this is a sign of healthy tension in a community mental health program.

Our strong impression in several crisis programs (notably East Oakland Crisis) is that this tension, fostered by administrative neglect, has become a chronic battle in "philosophy," between those favoring total program emphasis on meeting one need or the other. This kind of argument is untenable for community mental health centers which purport to provide comprehensive services mandated by law; and it ignores the primary therapeutic responsibility to provide appropriate treatment for particular problems.

The relationship between Berkeley Crisis and Berkeley Adult Outpatient programs, though unsettled, might serve as some example for the design of services here. When clients are judged to require longer term treatment they are immediately referred to an outpatient therapist; also, for crisis cases seen more than a few times, crisis staff can continue seeing clients on a longer term basis in the outpatient clinic. In any event, the existence of a so-called "traditional" psychiatric outpatient program in the complex of Berkeley programs relieves Berkeley Crisis of attempting to meet all service needs in a short-term context which is exactly the impossible bind all other crisis programs are now experiencing.



b) Variety of Services Available, by "Modality" (Cont'd)

Rehabilitation Services

WE CONCLUDE that most mental health rehabilitation programs provide an inadequate range of both clinical and social rehabilitation services because these programs were unnecessarily separated from crisis and adult outpatient programs in 1973. Both Rehab and Crisis program are limited by this separation.

WE RECOMMEND that the crisis and rehabilitation programs within each loose district "center" be joined by degrees of usefulness through shared staffing arrangements which allow for adequate medical, clinical and social services for the clients of both programs.

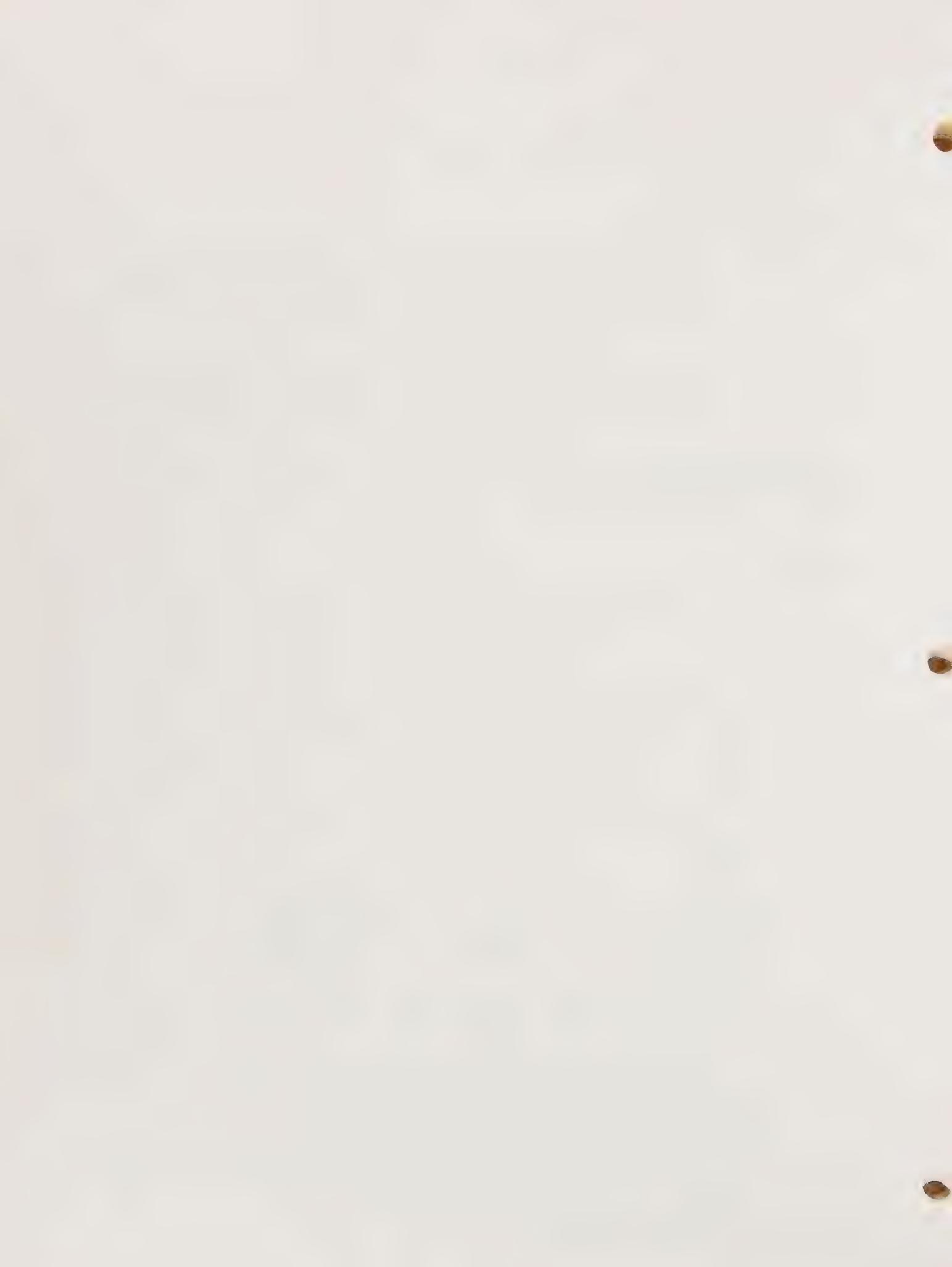
WE FURTHER RECOMMEND that Rehab programs make full use of available CETA funds to provide pre-vocational training services to the many clients in their caseloads who need them.

SUPPORT:

Initial staffing of Rehab programs called for one, one-half time psychiatrist per program, in order to emphasize social service needs. An unintended consequence has been that large numbers of Rehab clients using anti-psychotic medications were concentrated into programs with minimal psychiatric coverage. Our impact of treatment study discloses the following percentages of clients receiving medication in each program:

Berkeley.....	26%	Valley.....	71%
Central.....	75%	West Oakland.....	61%
East Oakland.....	59%	CCSS Hayward.....	61%
Alameda.....	63%	(disconnected from	
Tri-City.....	77%	Eden Rehab)	

Although some of these Rehab clients receive medications from private psychiatrists, the general impression of most psychiatric staff in Rehab, Psych Emergency and Crisis programs is that the consistency of medication review of Rehab clients has been poor. SRS funding ceased as of July, 1975; no barrier can possibly exist to adequate psychiatric staffing of Rehab programs now.



- * The only Rehab program providing substantial pre-vocational services are Eden Rehab, which has successfully obtained CETA funds, and West Oakland Rehab, which has obtained a variety of funds for its Industrial Therapy Program. (See site analyses for all Rehab programs. See also Section VII, Linkages, describing weakened connections for all Rehab clients with State vocational rehabilitation counselors.)
- * Rehab programs serve a fair number of severely disturbed persons who require periodic crisis intervention services to avoid hospitalization, or hospitalization itself, as well as more sustained, long-term supportive services. Rehab staff are generally not trained or expected to perform crisis intervention or home visiting services, but call upon Crisis programs to provide these for Rehab clients, thus unnecessarily involving many staff with a few clients.
- * State CCSS workers are assigned to functional duties in each district Rehab program, bringing with them some combination of former responsibilities as primary liaisons to board and care homes, and the availability of Family Care Funds to provide temporary board and care funds for those without SSI or other funds. Crisis programs, on the other hand, see a considerable number of clients in emergent need of temporary housing but are blocked from using Family Care Funds or board and care homes by Rehab programs' general admission policies requiring that referrals be made only on a non-emergent basis. This is confirmed by our survey data that indicates that 40 percent of crisis program staffs rate residential placement services in their programs as "not applicable." This function is seen as not theirs, or as inadequately performed. A trial program for a "Crisis House" in East Oakland (see Volume III) was an unsuccessful attempt to bridge the gap between these services.



Variety of Services Available by "Modality"

Day Treatment Services

WE CONCLUDE that adult day treatment programs generally in the County are providing excellent clinical services, required not only to prevent hospitalization or reduce the length of hospitalization, but also to re-integrate seriously disturbed persons to a significantly higher level of functioning in the community.

WE COMMEND the individual day treatment programs and strongly suggest that the County direct program evaluation efforts to study the effectiveness of these programs as potentially the most valuable tools for providing increasing outpatient alternatives for inpatient hospitalization.

SUPPORT:

- * See site analyses for the five adult day treatment programs (Berkeley Day Treatment, West Oakland Day Treatment, Central Day Treatment, Gladman Day Treatment and Eden Day Treatment).

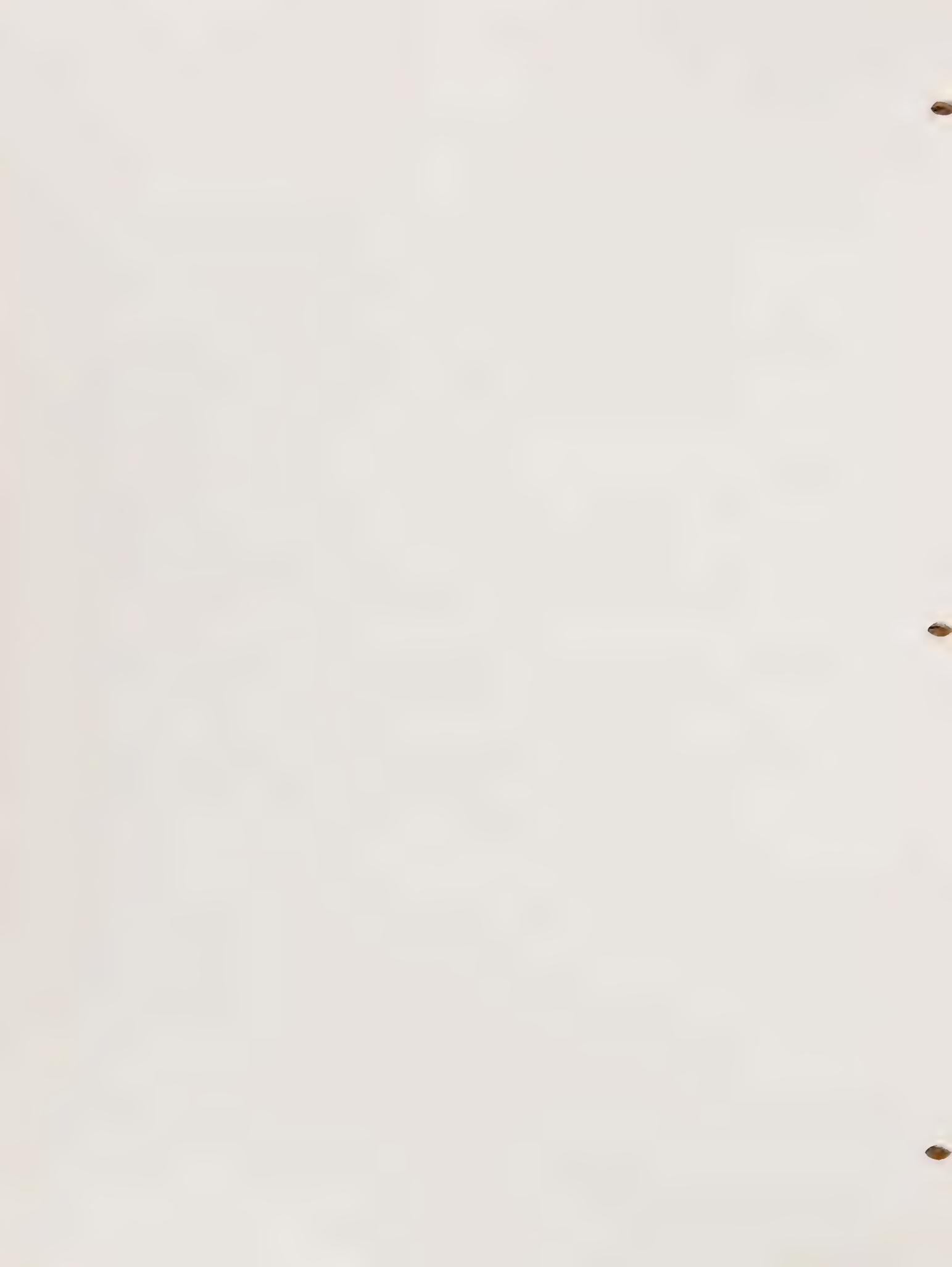
WE CONCLUDE that linkages to day treatment from some major intake (crisis and psychiatric emergency) programs designated for evaluating for hospitalization are practically non-existent.

WE RECOMMEND that regional mental health directors review existing linkages between all day treatment programs and all present or potential sources of intake in each region, to determine which linkages require strengthening or modification according to priority needs of the respective regions.

SUPPORT:

- * Depending on the major emphasis or combination of emphases of each day treatment program, present district policies usually require most non-private referrals to day treatment program to come through the respective district crisis programs.

Our client tracking study, based on disposition logs, disclosed the following total number of referrals over the three-month study period between programs:



Highland Psychiatric Emergency to:

Central Day Treatment.....	0
Gladman Day Treatment.....	0
West Oakland Day Treatment.....	0
Berkeley Day Treatment.....	0
Berkeley Crisis to Berkeley Day Treatment.....	4
East Oakland Crisis to Gladman Day Treatment.....	1
West/North Oakland Crisis to West Oakland Day Treatment....	8
Central Crisis to Central Day Treatment.....	0
Fairmont Psychiatric Emergency to Eden Day Treatment.....	3
Eden Crisis to Eden Day Treatment.....	0

Children's Programs

WE CONCLUDE that children's programs generally are outstanding in providing individual and family therapy and in energetic consultation with other agencies. Group treatment and home visits need to be strengthened in most outpatient program, however.

WE COMMEND these programs, and suggest that they explore the possibility of utilizing more paraprofessional staff with the goals of:

- a) serving more clients, and
- b) possibly freeing some staff to provide day treatment services.

*Site analysis of children's programs describe general understaffing relative to adult programs. An attitude exists among most children's staff that their programs are the step-child of County mental health programs, and get the lowest priority among other needs. Children's programs were the last to be completely "districted" among other outpatient programs, barely in time for the "de-districting" which has already begun. One result has been that certain programs were underutilized while others have large caseloads.

*See Section "Consultation Impact".

WE CONCLUDE that North Region has at least minimal residential and day treatment services for exceptionally disturbed youth, although each of those programs is very limited in capacity; and South Region has no residential or day treatment capability for serving children.



WE RECOMMEND that a needs assessment direct the assignment of priorities for possible directions of new program development.

WE FURTHER RECOMMEND that Probation Guidance Clinic staff be utilized in part in efforts indicated by the needs assessment and in ways which promise to yield more effectiveness than past efforts have yielded.

*See site analyses in Volume III for East Bay Activities Center, Lincoln Child Center, Fred Finch Residential and Fred Finch Day Treatment programs.

*See section "Consultation Impact".

WE CONCLUDE that the design of children's programs in East Oakland is such that, inadvertently or by intent, black children are generally seen at East Oakland Family Health Center; Chicano children at El Centro de Salud Mental; and white children by one therapist at East Oakland Crisis Services or possibly by programs in other districts.

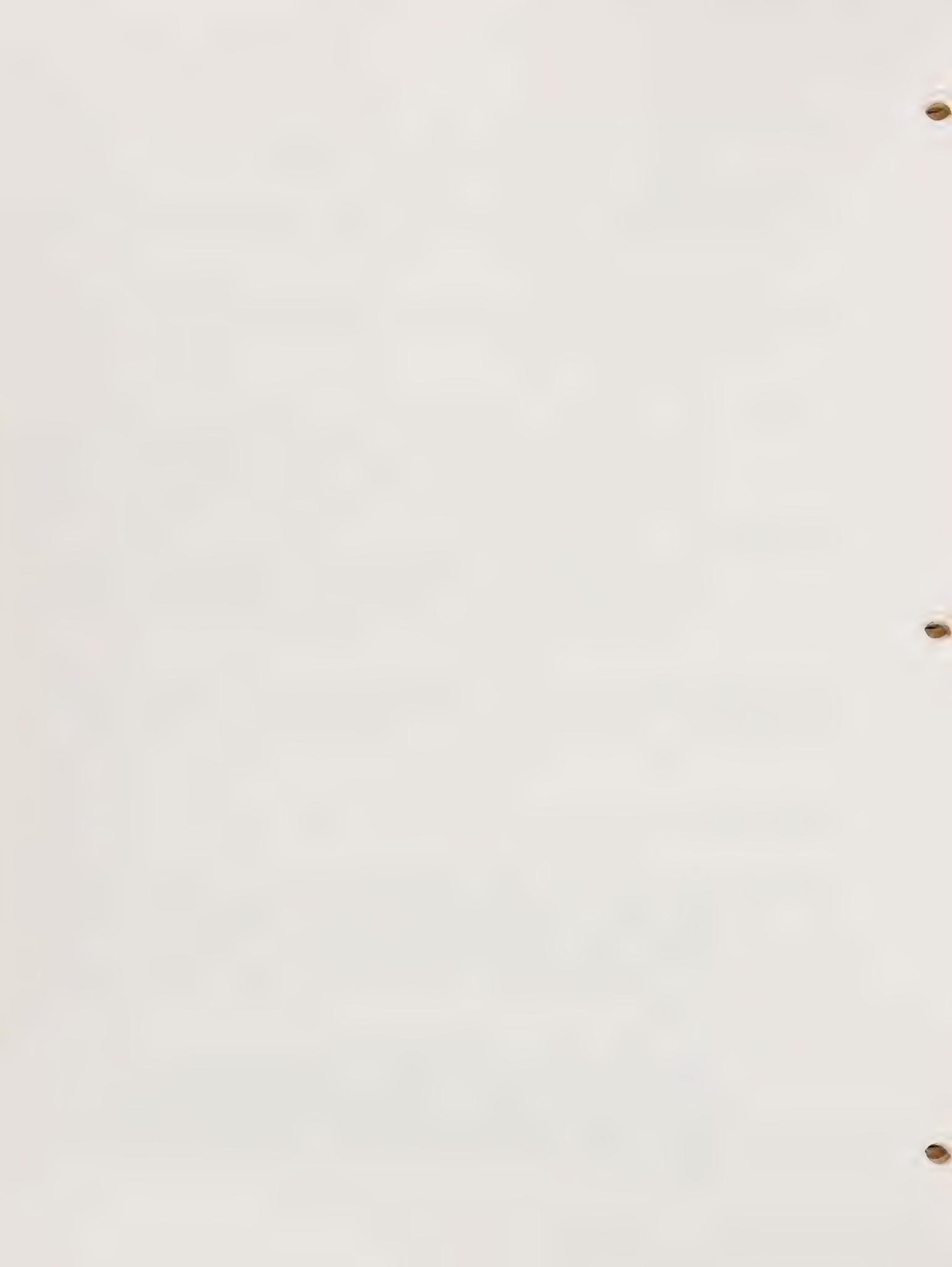
WE RECOMMEND that the North Region directors review the design of children's programs in East Oakland Community Mental Health Center, in conjunction with regional planning staff, to determine if this design based apparently on racial and cultural groupings is best suited for meeting the needs of East Oakland resident.

*Contracts for children's programs, and staffing patterns for East Oakland Crisis Service support the impression of programs distinctly separated along cultural and racial lines. See also next section, "Contract Programs to Serve Ethnic and Cultural Groups".

c) Contract Programs to Serve Ethnic and Cultural Groups

WE CONCLUDE that Mental Health Administration has not consistently reviewed the coordination and integration between County-funded community-based mental health programs (El Centro de Salud Mental, East Oakland Family Health Center, West Oakland Health Center) and other County-operated programs, to ensure that maximum benefits are derived in County-wide services to underserved cultural or ethnic groups.

WE RECOMMEND that Mental Health Administration regularly review the degree and kinds of coordination and integration which exist between present (and future) County-funded contract programs and other program elements in the larger system; and that Mental Health Administration actively facilitate the maximum degree of interaction between programs consistent with the welfare of all underserved cultural or ethnic groups.



See site analyses for these programs in Volume III which state that:

- referrals do not occur between El Centro and any other County-funded programs.
- East Oakland Family Health Center and several County-operated programs appear to be troubled by an absence of mutual agreement about what constitute appropriate referrals.
- Asian Community Mental Health Services has been forced by language barriers in County-operated programs generally to begin providing direct clinical services to Asian clients before funding has been approved to do so.

*Central district staff frequently complain about the absence of coordination between their programs and those of West Oakland Health Center who frequently serve many of the same clients.

*Regular meetings among all the program elements funded by NIMH for a "Community Mental Health Center" in East Oakland have not occurred in over a year.

*No regular communication between programs explicitly funded to serve particular population groups, and County-operated programs, has occurred to educate County-operated programs about the mental health needs and the services appropriate for the people on whose behalf these contract agencies exist, so that the capability of County-operated programs to serve these groups when necessary has not been enhanced through the process of contracting.

d) Question: Which program or program modalities are troubled by professional standards, or issues around the competence of staff to perform assigned functions according to training and capacity?

WE CONCLUDE that the programs most troubled by issues involving professional standards or staff competence are: East Oakland Crisis, East Oakland Rehab, Central Rehab, Berkeley Rehab and Alameda Clinic. The Rehab programs are troubled in large part from differences between CCSS and other Rehab staff.

WE RECOMMEND that those program identified as troubled by professional standards be given priority attention from Regional administrators.

SUPPORT:

- * Survey data describes the following distribution of 310 clinician responses to the question, "To what extent do your own clinical standards match in practice those of other therapists in your program?"

	<u>CONTRACT</u>	<u>COUNTY</u>	<u>TOTAL</u>
(usually agree with treatment)	73%	65%	67%
(disagree but accept as valid)	22%	21%	21%
(sharply disagree)	2%	8%	6%

*Ratings of other staff in one's own program in their competence to perform assigned functions according to training and capacity:

everyone working at <u>appropriate</u> level	43%	25%	31%
<u>most</u> are appropriate	51%	27%	55%
only students beyond	-	-	1%
<u>many</u> working beyond	3%	14%	10%

*Based on this data alone, most troubled sites are: East Oakland Crisis East Oakland Rehab, Berkeley Rehab, Central Rehab, Alameda Clinic, CCSS Hayward (disconnected from Eden Rehab).

*See site analyses in Volume II for each of these programs. Survey results for these two questions are not repeated here by individual programs. Suffice it to say that these programs are the main sources of the percentages of response in categories of "sharply disagree" and "many working beyond" in the data presented above, signifying an absence of clear standards of practice in relation to professional training to govern the level of work performed or supervision provided.

*See also Section VII, Linkages Between Mental Health and Other Services, for a discussion of CCSS/Rehab program relations.

*We note that since their transfer to Mental Health Services (into Rehab programs primarily) from Public Health several years ago, the Mental Health Aides as a group have been provided virtually no training, or even systematic review of the training, supervision they receive in their respective programs. Similarly, no efforts have been made to review the levels of practice, training and supervision provided to Community Mental Health Workers, though Civil Service did complete a reclassification of these positions from existing Psychiatric Technician class.

*A result at the level of programs has been the choosing of "sides" between those who favor loose team operations and those who are cast in the role of upholding the "medical model" of practice inappropriately in a community mental health



center. Practices in the programs vacillate between laissez-faire non-structures and brief, unsuccessful efforts to establish supervision or other structures to define levels of practice and review service delivery. Efforts to clarify some of these issues have reached the level of Agency Director.

*We view the responsibility for establishing standards of practice in an orderly process to be that of regional clinical administration.



3. CONTINUITY OF CARE

Continuity of care is defined here as the relatedness between past and present care, in conformity with the client's therapeutic needs. It exists when:

- a) there are no obstacles to a client's remaining in or moving from any of a group of treatment services, and
- b) administrative mechanisms relate past and present service by providing:
 - stable client-clinician relationships
 - necessary communication among clinicians participating in the client's service program.
 - contact with clients who miss appointments or go on unauthorized leave or fail to complete a referral and so appear to be dropping out of treatment.*

In this section some aspects of continuity of care in the complex of mental health programs in Alameda County are evaluated. It is anticipated that in future evaluations practices relating to continuity of care can be looked at more closely, as the Mental Health Service has just now begun a new system, the Referral Confirmation System, to promote accountability in referrals made between publicly-funded programs.

The aspects of continuity addressed here include: case recording standards and practices, availability of care records, referral practices between publicly-funded programs, and referrals to the private sector.

A) Case Recording Standards and Practices

WE CONCLUDE that there is wide variance in written standards for case recording among County-operated programs depending on the service modality, the health district and the region of the County of which they are a part. This variance is the result of a lack of administrative attention during the rapid expansion of programs during the past three years.

WE RECOMMEND that Mental Health Administration proceed with its current review of case recording standards and practices and establish formal requirements on a County-wide basis, along with a policy for monitoring by administrative supervisors.

* Adapted from Rosaly D. Bass, MA, AGS, "A Method for Measuring Continuity of Care in a Community Mental Health Center," NIMH Mental Health Statistics, Series C, No. 4, 1972.



a) Case Recording Standards and Practices (Cont'd)

*Furnished with copies of existing procedures and a status report from each district, we note that psychiatric emergency program procedures have been most recently updated in light of a new case record. Inpatient services continue to use an outline format developed several years ago, much as the Probation Guidance still has a procedures manual that has been altered little in several years.

The various district outpatient programs generally have no procedure manuals including case recording standards at all, or some that are completely outdated. Plans are noted for establishing a "problem-oriented record" by the South Region Training Office for Eden and Washington Districts. Central and Eastern Districts report no procedure manuals, but have only a "verbal understanding" to govern case recording.

We note that the absence of case recording standards and procedures makes it impossible for any evaluation of case recording practices. Needless to say, monitoring by program administrator's cannot occur under such circumstances either.

We are concerned that no standards or review of case recording practices has occurred for several years in the outpatient programs. Many of these programs include a considerable number of paraprofessional staff whose formative work in outpatient settings has included no training or recognition of the uses of case recording. The absence of standards may seriously hamper the capability of Rehabilitation programs, for instance, to respond to such requests for information as those made by the Social Security Administration, requiring psychiatric histories/evaluation in order to process SSI applications for clients seen at the Rehabilitation programs.

* Case recording standards and practices in contract programs are supposed to be modelled in County programs. Many contractors have well-defined standards and practices which they have developed for their own needs.

WE CONCLUDE that the recent institution of the Crisis Service Brief Record system in County-operated crisis programs has met an urgent need for improving the capability to serve drop-in clients with a minimum of paperwork, and also made it possible for charges to be appropriately set for information inquiries versus clinical interviews.

WE COMMEND the Mental Health Service for improving its capability for serving drop-in clients.

WE CONCLUDE that the brief record systems used by County-operated Crisis Services and Psychiatric Emergency Services are not linked adequately with the chart kept by Central Records, so that these programs must serve clients with incomplete information available about services received elsewhere in the system.



WE RECOMMEND that Mental Health Services devise means to improve the linkage between brief records and central records systems.

SUPPORT:

Prior to the institution of brief records in crisis programs, it was necessary to open a complete chart for each client seen, even briefly, who required a medication prescription. The status of clients making even brief information inquiries was ambiguous from the standpoint of charges to be made for the visit. Both problems were resolved by adapting the format of the brief record system used for some time by Psychiatric Emergency to the crisis programs. Yet both systems appear to us to be inadequately linked to Central Records at Highland Hospital. (See (b) below)

b) Availability of Records for County Programs

WE CONCLUDE that the Central Records system in County-operated programs, maintained at Highland Hospital, is inadequate. Several serious inadequacies stem primarily from the psychiatric and medical records systems being maintained together under the administration of Medical Institutions. Continuity of records from HPIS to outpatient programs is poor.*

WE RECOMMEND that the County Administrator review the status of these long-standing inadequacies in Central Records; handling of mental health records with Medical Institutions administration, in consultation with the Mental Health Director, and jointly determine whether they can be readily corrected, or whether the establishment of a separate system for Mental Health Services is required.

* For additional discussion, see Volume II, Billings and Liability.



WE RECOMMEND that copies of discharge summaries for patients admitted through HPES be forwarded to HPES for inclusion in patients HPES chart in order to improve the quality of future dispositions.

SUPPORT:

- * Responses to survey question: "How often have you had the following experiences with the County's central record system?"

	<u>Very Often</u>	<u>Occasionally</u>	<u>Rarely</u>
Delay of more than two days getting closed charts	50% (33%)	16% (30%)	10% (12%)
Inaccurate information given about chart location	12% (16%)	33% (35%)	28% (23%)
Central Records reports a chart is "lost"	12% (21%)	35% (35%)	12% (23%)
Records from HPIS go to Central Records for more than a week before getting to outpatient program following client discharged.	31% (16%)	19% (16%)	16% (16%)

[Note: clinician responses are not bracketed; clerical responses are bracketed (%)].

*Informal survey of outlying mental health programs reveal a strong reluctance to close most charts and send them to Central Records because charts will not be readily available in time after the return of a client to a program. All these inadequacies in Central Records are well-known and for the most part have been fatalistically accepted as a fact of life by mental health staff for years. The delay in forwarding records from HPIS is reported by many to often exceed two weeks or more. Out-patient programs have been generally unsuccessful in making accommodations for the delay; request to inpatient staff to copy even the most important portions of case records before sending the charts to Central Records have been unsuccessful because Inpatient staff have poor access to copying equipment and clerical staff have too many other duties to perform to assume this extra duty.



*Survey data for clinicians rating their own programs' referral practices to other County-operated or contract programs provide the following spread:

(EXCELLENT)	(GOOD)	(FAIR)	(POOR)
27%	51%	16%	3%

However, when asked to express agreement or disagreement with various administrative actions that could affect continuity of care among mental health programs in the County generally, the following results were obtained:

	Agree	Not Sure	Disagree
No suggestions needed, since continuity is already high for most referrals in the system	4%	21%	66%
Establish liaison workers from each program to each and all other programs with which there are many referrals	63%	24%	7%
Re-define the range of services performed by each program so it will be clear which client to refer to what program.	57%	28%	7%
Establish a uniform referral procedure in the county, with ways to monitor effectiveness	48%	36%	9%
Generally improve existing Central Record system for mental health charts	39%	40%	11%
Centralize relevant data by computer with proper safeguards for confidentiality	26%	35%	31%

WE CONCLUDE that the referral linkages between Highland and Fairmont Psychiatric Emergency Services and all other outpatient programs, which include the greatest number of referrals anywhere in the system, is the least adequate linkage area in the entire complex of programs.

WE RECOMMEND that the service chiefs of the respective psychiatric emergency services take the following actions:

1. review procedures for referral and expected usage of the referral confirmation system with their own programs, and
2. themselves review and regularly monitor the records of referrals made to ensure that documentation exists showing both that the client understands that a referral was made, and that a description is made of the level of effort required by outpatient programs for follow-up.

SUPPORT AND DISCUSSION

*Our client tracking study of 95 cases referred from points of initial contact to outpatient programs showed a very poor rate of success (34%) as noted above. This percentage, however, includes 13 percent success rate of cases referred from psychiatric emergency services, compared with a 69 percent success rate of cases referred by all outpatient programs combined, to other outpatient programs.

*Of the 60 referral records studies from the two psychiatric emergency programs it was noted that 44 records had either ambiguous (17) or no (27) information at all regarding the level of effort to be expended by outpatient programs in follow-up of the referral, and few showed any description of who was to do what in the follow-up process, or even that the client had acknowledged that referral had been made.

Factors which we recognize to affect these referrals rates from psychiatric emergency services include the large number of outpatient programs with whom referral linkages and understandings have to be maintained; the high percentage of clients seen in emergency who are unwilling or ambivalent about wanting follow-up elsewhere; and finally these problems are compounded in 24-hour programs by evening and weekend staff who know little or nothing about the outpatient programs they are referring people to. We note also that there has been no consistant practice in routing copies of Psych ER "referral" records to outpatient programs, and no consistant practices from one outpatient program to another in methods to follow-up on referrals from psychiatric emergency programs.



WE CONCLUDE that the "center" model of arranging mental health programs appear to hold promise for improvement in continuity of care, based on examples of high referral success between the Berkeley programs, and between the West Oakland Health Center programs. Shared staffing and other linkages mechanisms appear to promote some viable strong identity among the programs within the "center".

(See Recommendations under Program Design).

*Client tracking study following referrals from Berkeley Crisis to Bereeley Rehab and Berkeley Day Treatment disclosed no cases in which the client had not at least been interviewed once. (Total sample: 5)

Client tracking study following referrals from the North and West Oakland Crisis programs to West Oakland Rehab and West Oakland Day Treatment disclosed only two cases with no record of referral (sample selection at both Crisis programs was extremely difficult, so it is possible no referrals had been intended - see site analyses for these programs), and all other cases accepted for treatment. (Total sample: 15)

All other County-operated outpatient programs receiving referrals had a fair proportion of cases never seen, or no record of the referral on hand, from other outpatient programs.



*A practice accomplished by Fairmont Psychiatric Emergency Service on all patients it sends to Highland for hospitalization is worth noting here. A copy of the discharge summary from Inpatient is sent to FPES where it is attached to the top of the patient's Psych Emergency file, so that FPES staff are informed at the patient's next visit as to which program is following the patient after discharge. This aids clinical staff in being able to contact the follow-up program to try to avoid re-hospitalization, or to make different recommendations for subsequent hospitalizations. This system may be worthy of consideration for Highland Psychiatric Emergency as well.

c) Referral Practices Within County-Funded Programs.

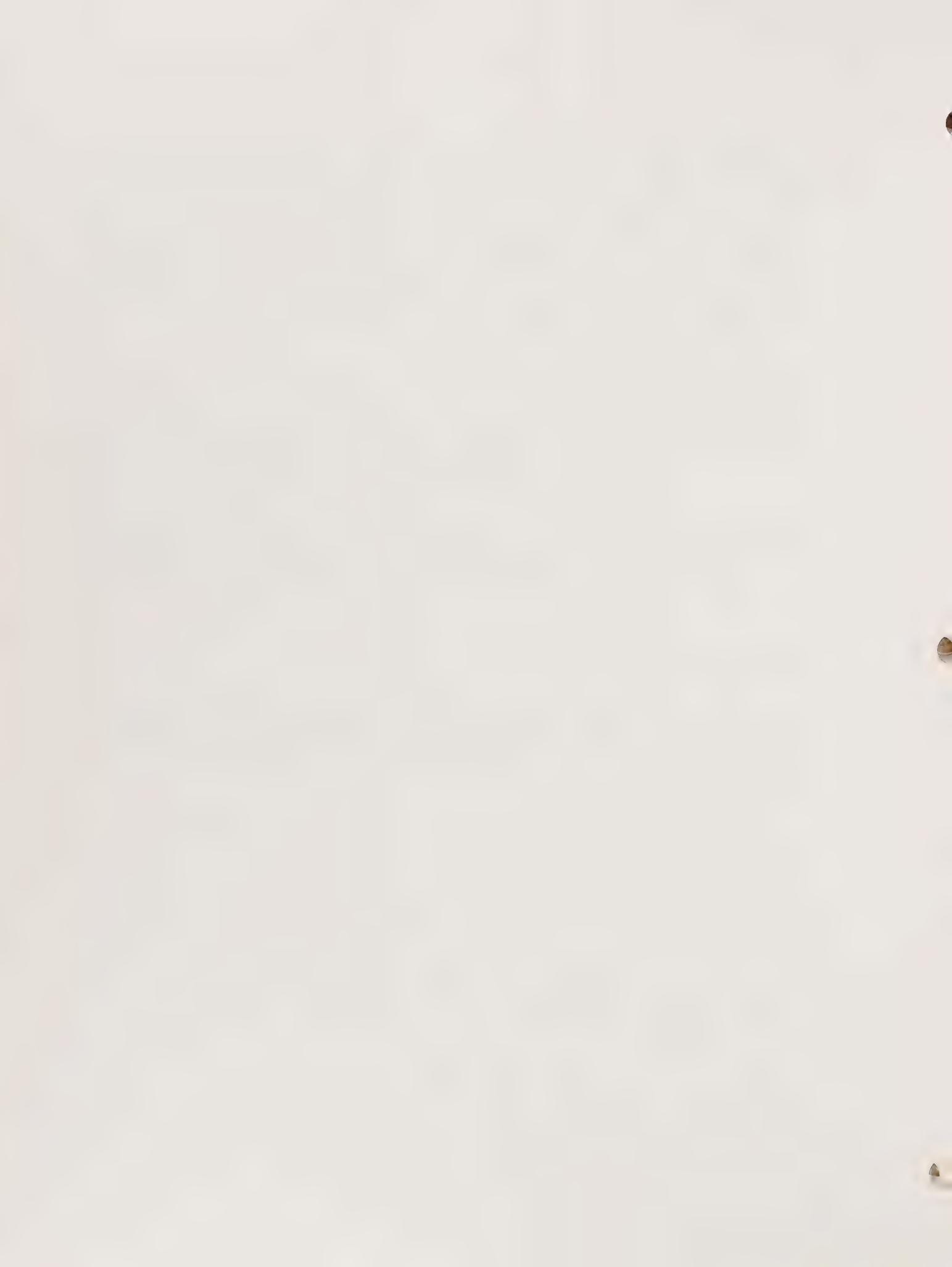
WE CONCLUDE that before February, 1976, when Mental Health Services implemented a formal referral confirmation system, referral practices among the various mental health programs in the County provided no uniformly reliable continuity of care.

WE COMMEND the Mental Health Services and recommend that complete implementation of the referral confirmation system be pursued, including regular review and monitoring of referral effectiveness.

SUPPORT AND DISCUSSION:

*Client Tracking study conducted prior to implementation of Referral Confirmation, describes the following overall results for 95 referrals made from intake programs to other mental health programs in the County system.

Accepted for treatment	32	34% Successful
Seen and re-referred	6	
Not seen	35	66% Not
No record of referral or case at program referred to	21	Successful
Still "pending"	1	
TOTAL	95	



d) Referral Practices Between County-Funded Programs and the Private Sector

WE CONLCUDE that there are no overall policy standards in the County network of mental health programs for referrals to private mental health resources; few mechanisms in any program for consistently following up on referrals; and no mechanisms in any programs for appraising the results of past referrals for use in a resource file compiled by each program.

WE RECOMMEND that the Mental Health Director and Regional Directors develop an overall policy for private refel and devise mechanisms for programs to use in following up. The expectation should be made clear that the results of past referrals are to be appraised and used in a resource file available in each program.

SUPPORT AND DISCUSSION:

*Lanterman-Petris-Short Act, 5008 (d) specifies that: "Each agency or facility providing evaluation services shall maintain a current and comprehensive file of all community services, both public and private. Such files shall contain current agreements with agencies or individuals accepting referrals, as well as appraisals of the results of past referrals."

*Clinician surveys show the following ratings of adequacy of continuity of care in their own programs in following up clients referred to private care:

	COUNTY	CONTRACT	TOTAL
Clear policy/procedure for contacting client or provider to determine referral result	10%	34%	18%
Most of us try hard but no systemmatic effort made to follow unless someone contacts us again	57%	39%	48%
I (personally) don't make referrals, so don't know	20%	21.5%	20%
Our staff does not know how and/or doesn't try hard to make referrals and seldom follow-up unless forced	3%	3%	3%



*Surveys describe the status of resource files in programs, usable to assist in referral to community resources generally, as follows:

"I have to rely on information I have collected on my own."28%

"Some of our files are useful but I often rely on other sources." ...17%

"We have resource files which make referral easy."44%

(percentages vary little between County-operated and contract)

*Does your program have a written policy and procedure to guide referral to private practitioners?

	<u>COUNTY</u>	<u>CONTRACT</u>	<u>TOTAL</u>
YES	30%	22%	27%
NO	58%	63%	60%

*How are the results of past referrals to private practitioners appraised for future reference in your program?

Almost no appraisal in my program.....24%

Informal appraisal, but nothing added to resource file.....43%

Resource file sometimes updated in light of past experiences.....11%

Resource file contains appraisal of results based on practice of sending inquiries to client or provider..... 6%

(Percentages vary little between County-operated and contract)

*About half the clinicians in County-operated programs refer one or more clients per month; contract clinicians make significantly fewer (only 30 percent make one or more per month) private referrals.

*FPES has developed one mechanism for systematically contacting private providers to determine if the client is being seen, and asking for feedback regarding the appropriateness of the referral. This might serve as a model for Mental Health Service planning to devise useful mechanisms for follow-up and appraisal of referral results.



4. RESPONSIVENESS

This last section looks at mental health programs' collective and individual relationships with the broad community. We present this from two viewpoints. First, consumer satisfaction with services received is viewed as a general indicator of the quality of service delivery and relationship with the community. Second, community education efforts are viewed in two overlapping parts: efforts to secure visibility for particular programs, and efforts to educate the community on mental health issues.

a) Client Satisfaction

Objective: Our objective in conducting a client satisfaction survey was to obtain some indicator of how clients feel about the services they receive. This is an essential part of the equation in evaluating mental health programs. We do not view satisfaction as an indicator of the impact, per se, of services. Rather, it is a value in itself, one important indicator of quality (see OPE final work program).

Methodology: A brief note of introduction was attached to a one-page written questionnaire containing 11 questions. One set of questions was used for adult clients in Day Treatment, Rehabilitation and Crisis programs; the same set with slightly different wording was used for children and parents in Children's programs. Questionnaires were translated into Spanish and into four Asian languages where necessary. The note and questionnaires were handed out for the most part by clerical staff to current clients attending most of the programs in this evaluation. The surveys were completed privately and mailed directly back to OPE. A set of instructions for administration was prepared by OPE for all program staff involved. Exact administration was tailored to each program; blanket exclusions were allowed for some client groups for whom the questionnaire was considered clinically damaging.

Interpretation of Results:

The 11 survey questions included three which we combined to see as a general indicator of satisfaction (Were you helped? Are you satisfied with the services? Would you recommend this program to a friend?). These questions are the bases for our conclusions below. The remaining questions dealt with issues of accessibility and range of services; responses, where significant, were included in individual site analyses in Volume III.

General Results:

The response rate for Client Satisfaction was 535 questionnaires returned out of 879 questionnaires handed out, or a rate of 61 percent returned. This is significantly higher than similar studies done elsewhere.

WE CONCLUDE that clients in all mental health programs surveyed are satisfied with the services they are receiving.

SUPPORT:

* Survey results show:

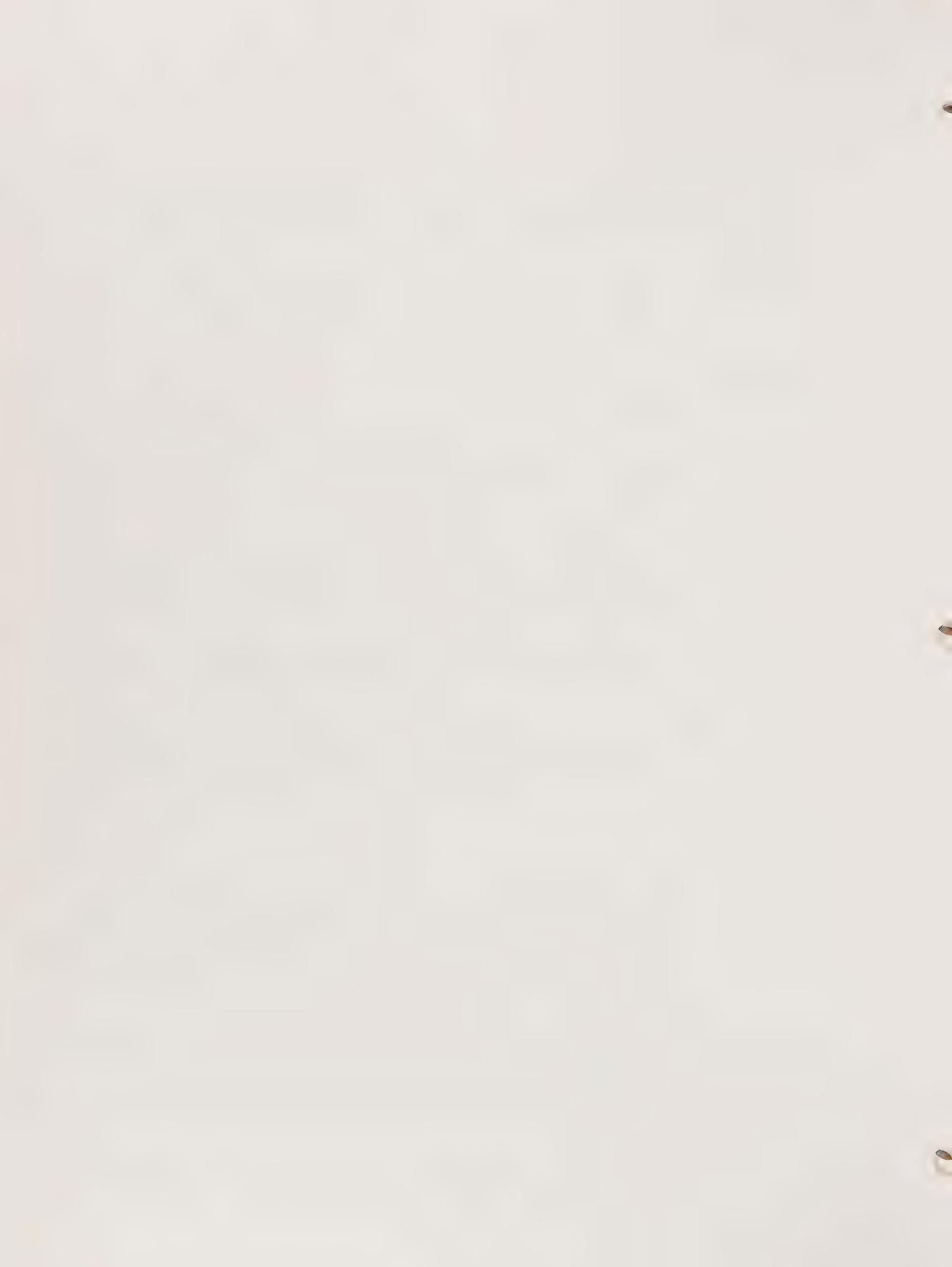
- 96 percent of sample feel they have been helped a great deal or to some degree, including:
 - 58 percent - a great deal
 - 38 percent - to some degree
- 56 percent of sample indicates they are very satisfied, and 34 percent indicate they are satisfied with the services they are receiving.
- 77 percent of sample would definitely recommend the program to others; 17 percent indicated "it depends".

WE CONCLUDE that some variance exists between County-operated and contract programs in that a higher level of satisfaction is found in clients of contract programs.

SUPPORT:

* Survey results show:

- 68 percent of contract program clients indicate they have been helped a great deal, and 29 percent to some degree; compared to County-operated programs where 50 percent indicate they have been helped a great deal, and 46 percent to some degree.
- 61 percent of contract program clients indicate they are very satisfied and 32 percent satisfied with the services they received; compared to County-operated program clients who indicated 52 percent very satisfied, and 36 percent satisfied.
- 77 percent of contract program clients would definitely recommend the program to others; compared to 76 percent of County-operated program clients.



SUMMARY RESULT OF THE CLIENT SATISFACTION SURVEY



SUMMARY RESULT OF THE CLIENT SATISFACTION SURVEY (cont'd)

		Berkeley Crisis	Berkeley Rehab	Berkeley Day Treatment	West Oakland Day Treatment	North Oakland Rehab	West Oakland Crisis Out/patient	Ann Martin Crisis Out/patient	Asian Mental Children's Center	Central Health Rehab	Central Day Treatment	Central Child Development	Gladman Day Treatment	Ahameda Mental Treatment	East Oakland Health	East Oakland Health Alliance	El Centro	East Oakland Health	Fairmont Crisis	Eden Crisis	Eden Children's Service	Eden Day Treatment	Tri-City Crisis	Valley Child Development	Tri-City Development	Valley Rehab	Valley Crisis	Total			
1. Do you feel you have been helped by something here?	A yes, a great deal	19	1	1	19	16	8	4	2	16	9	10	14	12	18	1	10	23	5	6	6	20	7	15	2	7	9	15	21	302	
	B yes, to some degree	22			7	7	7	6	3	3	4	2	9	8	13	1	7	7	2	5	8	17	12	11	3	7	4	3	11	201	
	C hasn't made a difference		1		1			2		1			1			1	1	1							2	2			16		
	D I feel worse												1			1									1	1		4			
2. Are there kinds of help you would like to have which weren't offered to you at this program?	A yes		9		3	6	3	3	1	2	4	1	2	9	8	8	1	8	5	2	2	2	7	7	5	4	2	2	4	110	
	B no	25	1		21	18	10	7	4	15	6	9	19	11	13	24	1	11	23	4	9	10	26	10	16	5	11	11	15	15	360
3. Are you satisfied with the services you are receiving here?	A very satisfied	24	1		13	14	10	5	4	15	6	6	11	10	8	21	1	8	27	4	6	10	21	8	16	1	3	7	14	22	296
	B satisfied	14	1	10	7	5	6	2	4	2	5	11	14	11	9	1	7	3	3	5	3	13	9	5	4	11	4	4	12	184	
	C somewhat	3		1	2					3		2	2	4		3	1	1	1	4	2	4		2	4	1	2	42			
	D not satisfied at all			2	1				1			1	1													1			7		
4. Do you feel you are getting what you expect from this program?	A yes, it's perfect	31	1		17	21	13	8	6	16	8	8	17	17	12	27	1	10	28	7	12	10	25	11	23	4	12	11	17	32	404
	B it's fine	7		7	1	2	3		3	2	3	5	7	9	6	1	6	3		3	8	5	2	1	3	1	1	1	1	90	
	C fairly, pretty good	3	1	1	2				1		1	1	1	1		2			1	3	3		1	2	1		1	25			
	D not particularly			1					1													1		1	1			5			
TOTAL QUESTIONNAIRES RECEIVED		43	1	1	26	26	15	11	6	18	12	11	24	25	22	35	2	19	31	7	12	14	38	19	26	5	17	16		535	
TOTAL QUESTIONNAIRES HANDED OUT		43	6	6	27	30	15	11	9	57	21	25	33	55	22	74	36	22	59	12	27	34	60	20	35	9	21	33		879	



b) Community Education

WE CONCLUDE that community education activities are relatively undeveloped in most programs in the County system. Community-based contract programs and children's outpatient programs appear to be the exception. The absence of a functional "district" or "center" design of programs is the main reason for this underdevelopment.

WE RECOMMEND that Regional Mental Health Directors provide specific support to each district or center group of mental health programs in developing community education activities which both raise the visibility of programs and educate the community itself about mental health issues. Facilitating the distribution of good brochures to raise visibility, and providing training and developing priorities for education, are the specific beginning points for this regional support.

SUPPORT:

- * 55 percent of 310 clinicians self-ratings of community education in their own programs fell in the fair - poor range. 51 percent of 35 service chiefs were in the same fair - poor range.
- * By district or "center" groupings, ratings by clinicians in strictiy outpatient programs give the following picture:

Berkeley contract programs	84% fair - poor
West Oakland Health Center programs.....	50% fair - poor
Central district programs.....	47% fair - poor
Alameda clinic	43% fair - poor
Asian CMH Services	100% <u>excellent - good</u>
East Oakland Crisis, Rehab and Gladman day treatment combined.....	81% fair - poor
East Oakland Family Health Center.....	62.5% fair - poor
El Centro de Salud Mental.....	94% <u>excellent - good</u>



Eden Crisis, Rehab, Children's and Day
Treatment combined..... 64%

Tri-City programs..... 46%

Valley programs..... 78%

* However, all district outpatient childrens programs (excluding PGC, day treatment or residential programs) show 87 percent excellent - good self=ratings.

* The new Mental Health Director has made community education a high personal priority. Berkeley programs have recently mapped out all "community consultation" activities performed by their cobined programs and evidently plan more systematic efforts in community education. Children's programs and most community-based contract programs appear to have considerable confidence in their efforts fo far.

* See Section IV "Consultation Impact" in this evaluation which describes other County programs as the largest consumer of mental health consultation services from mental health programs in the County.

* Service chiefs report whether their programs have "sufficient outreach into the community"

(respondents/Percentage of total number)

	COUNTY	CONTRACT	TOTAL
YES	6/33%	10/62.5%	5/28%
NO	12/67%	6/37%	18/53%



* Of the 18 programs answering "no", the following reasons are given why outreach falls short of their goals:

	<u>COUNTY</u>	<u>CONTRACT</u>	<u>TOTAL</u>
Program at or near capacity and more outreach would add to problems	2/17%	3/50%	5/28%
Program primarily geared for direct client service, not outreach activity	2/17%	2/33%	4/22%
We just haven't had time to do thorough job of outreach	2/17%	1/17%	3/17%
Other reasons	6/50%	0	6/33%

(respondents/percentage to total number)



APPENDIX: QUALITY

TELEPHONE ACCESSIBILITY

Methodology: Part I

Telephone Reception at any mental health program must be prepared to handle reasonable requests for information concerning a program's operation, location, cost and inquiries regarding a client that do not violate confidentiality.

To study this, the Mental Health Team engaged in a sample telephone call study, for use in its broad review of quality. These sample phone calls focused on entry requirements, physical accessibility, emotional accessibility and financial accessibility.

Eighteen scenarios were developed for the sample phone calls which encompassed all these areas. To insure that calls were appropriate, we pre-tested scenarios to different modalities. Each program was then called at least once with the results recorded on the Telephone Accessibility Tally Sheet. This Tally Sheet gave information on the program called and the scenario used, and also rated the quality if information, referral and reception services provided.

Methodology: Part II

In the second part of this study, the Mental Health Team sought help for a mental health problem by calling directory Assistance and utilizing the local telephone directories as starting points. In addition, some Alameda County residents who had no prior contact with mental health services were enlisted to perform the same test.

The scenario used for each call was, "I want to talk to someone about these crazy thoughts I've been having. I'm not suicidal. Can you help me?"

Time span: The phone calls were made from the week of February 9 to March 12, 1976.

Ratings:

Based on the criteria on the Telephone Accessibility Tally Sheets, subjective ratings of "excellent", "good" and "poor" were made on each call. In several cases follow-up calls were made to insure some quality control. In each case similar results were produced.

The following documents are the instruments used in the study:

- 1) Definition of the five levels of accessibility
- 2) How services were grouped to match scenarios
- 3) The appropriateness of scenarios to modalities
- 4) The scenarios used



FIVE LEVELS OF TELEPHONE ACCESSIBILITY

1. ACCESSIBILITY - Physical:

- a) Where to go to get help.
- b) Transportation information for users of public transportation.
- c) Information for car drivers including where to park.
- d) Useful information to help visually handicapped find service (prominent signs, significant landmarks, street address)

2. ACCESSIBILITY - Temporal:

- a) Hours open
- b) Where to go if a service is closed
- c) What kinds of delays exist between switchboard, clerical, and clinical staff.
- d) Is no-wait intake available?

3. ACCESSIBILITY - Emotional

- a) Limited in English language?
- b) Availability of diversity of staff by sex, age, race, religion, (or: How does services handle inadequacies in this area?)
- c) The nature and quality of telephone information available.
- d) Is there child care available, if not what does service suggest?
- e) Is there a willingness to work together with other services, parent and friends?
- f) Availability and flexibility of treatment modes.
- g) What are the attitudes of service staff responding to appropriate and inappropriate information requests?
- h) How are complaints handled over the telephone?
- i) How is confidentiality handled?

4. ACCESSIBILITY - Entry Requirements:

- a) Ways in which entry requirements may hinder usage (i.e., district, hours of operation)



Five Levels of Telephone Accessibility (Cont'd)

5. ACCESSIBILITY - Financial:

- a) Are costs explained and if too high, what does service suggest?
- b) Are clients referred elsewhere if UMDAP exceeds cost in private sector?



TYPES OF MODALITIES

Rehabilitation Services

1. Berkeley Rehab
2. West Oakland Rehab
3. Central Rehab
4. East Oakland Rehab
5. Eden Rehab
6. Valley Rehab
7. Valley Rehab

Crisis Services and/or primary mental health intake points (excluding psychiatric emergency services).

1. North Oakland Crisis Outpatient
2. West Oakland Crisis Outpatient
3. Central Crisis Service
4. Alameda Mental Health Clinic
5. East Oakland Health Alliance
6. El Central de Salud Mental
7. East Oakland Crisis
8. Fairmont Crisis
9. Tri-City Valley
10. Valley Crisis

Adult Day Treatment Services:

1. Berkeley Day Treatment
2. West Oakland Day Treatment
3. Central Day Treatment
4. Gladman Day Treatment
5. Eden Day Treatment

Indirect Services

Those services which do not carry ongoing active case loads and/or whose primary operations are largely dependent on telephone usage.

1. Mental Health Advocates
2. Suicide Prevention
3. Parental Stress
4. Asian Mental Health Service



Types of Modalities (Cont'd)

Psychiatric Emergency Services:

1. Highland Psychiatric Emergency
2. Fairmont Psychiatric Emergency

Inpatient Service:

1. Highland Inpatient Service

Socialization Service:

Those services whose primary function is socialization. These sites are called Creative Living Centers.

1. Townhouse CLC
2. St. Mary's CLC
3. Allen Temple CLC
4. Hayward Socialization Center
5. Irvington CLC
6. Four Bridges CLC

Outpatient Childrens Services:

1. Central Child Development
2. Ann Martin Children's Service
3. Fred Finch Day Treatment
4. East Bay Activity Center
5. Probation Guidance Clinic
6. Eden Children Service
7. Tri-City Child Development
8. Valley Child Development
9. Twin Valley Counseling

Residential Children's Service:

1. Fred Finch Youth Center
2. Lincoln Child Center



APPROPRIATENESS OF SCENARIOS TO MODALITIES

Scenario Number	Rehab	DTx	Crisis	Indirect	PES	INP	SOI	Out Child	Res Child
1.	+	+	+	s	+	o	o	+	0
a)	+	+	+	+	+	+	+	+	+
b)	+	+	+	+	+	+	+	+	+
2.	+	+	+	+	+	+	+	+	+
3.	s	o	+	+	o	o	o	+	o
4.	s	o	+	o	o	o	o	o	o
5.	s	o	+	+	o	o	o	o	o
6.	+	+	+	+	o	o	o	+	+
7.	+	o	+	+/s	+/s	+/s	+/s	+	+/s
8.	s	+	+	o	o	o	o	+	o
9.	+	+	+	+	+	o	+	+	+/s
10.	+	+	+	+	+	o	+	+	+
11.	+	o	+	+	o	o	o	+	+
12.	+	+	+	+/s	+	+	s	+	+
13.	+	+	+	o	o	s	+	+	+/s
14a)	+	+	+	o	o	o	o	s	o
b)	o	o	o	o	+	o	o	+	+
15.	+	+	+	+	+	+	+	+	+
16.	+	o	+	+	o	o	o	+	o
17.	+	o	+	+	+	o	o	o	o
18.	+	+	+	+	+	+	+	+	+

Key To Abbreviations:

Rehab - Rehabilitation Services
 DTX - Adult Day Treatment Services
 Crisis - Crisis Services
 Indirect - Indirect Services
 Res Child - Residential Children's Services

PES - Psychiatric Emergency Services
 INP - Inpatient Services
 SOI - Socialization Services
 Out Child - Outpatient Children's Services

+= appropriate to this modality

o = inappropriate to this modality

+/s = appropriate in some cases



SCENARIOS

Where to go for help: 1. My best friend is going through a crisis in her life. She says she hearing voices, and is always depressed. I think she needs psychiatric help. What can I tell her?

Accessibility by car: I can bring her. Can you tell me how to get there by car? I live at _____. Is there ample parking?

Accessibility by public transportation: 2. I have poor vision and I want to come to your place. I need bus information or Bart information.

Berkeley	use	2505 Benvenue Avenue
East Oakland	use	9320 Plymouth Avenue
Central	use	530 - 31st Street
Washington	use	33950 - 13th Str., Union City
Eden	use	22512 Woodrow, Hayward

Poor vision accessibility: Because of my vision, I sometimes have difficulty finding places. Are there large street signs on prominent street signs to help me find the place? Can you describe a way for me to find it? Are there specific landmarks around there?

Service taken to consumer: 3. My mother really seems to be getting more and more depressed. Can someone in your service come out and talk to her? (note: mother age 45.)

Berkeley	use	2505 Benvenue Avenue
East Oakland	use	9320 Plymouth Avenue
Central	use	530 - 31st Street
Washington	use	33950 - 13th Str., Union City
Eden	use	22512 Woodrow, Haywrrd



Scenarios (Cont'd)

§

- Temporal and Financial Accessibility:
4. I want to come down and talk to someone about these crazy thoughts I've been having. I work at Montgomery Wards, make \$800 per month and have a wife and two kids. How much will it cost me? (UMDAP LIABILITY \$12 per month). Same as above except "I work at Montgomery Wards, make \$1,500 per month and am married (no kids)." How much would it cost me? (UMDAP \$148).
- Temporal Accessibility:
5. I can't come between 8:30 a.m. and 5:00 p.m. Is there somewhere else I can get services?
- Temporal Accessibility
6. If I can get off for a short time, can I come in for a day time appointment and not have to wait?
- Limited in English Languages/cultural accessibility:
7. My father wants to find someone to talk to about his depression. He doesn't speak English though. Do you have staff that speak Spanish or know programs that do?
- Accessibility religious:
8. My daughter is having problems around birth control and what the Catholic Church says about that. She is becoming very depressed over the issue. She says she wants to talk to a Catholic therapist. Do you have such a person or what do you suggest?



Scenarios (Cont'd)

Accessibility
racial:

9. My son will only rap to someone who knows about Black consciousness. Do you have such a person? He would prefer a Black man too? (Note: can use Chicano, Asian, American Indian)

Availability of
telephone
information:

10. Can my husband call you and talk to a therapist about his problems? This might erase some of his fears about going to your program.

Child care
availability and
accessibility for
parents with preschool
children:

11. I would like to come to your place but I have three kids to take care of. Do you provide any child care or have toys for them to play with or make home visits? What do you suggest?

Willingness to work
with interested rela-
tives and friends:

12. If we get our son down to your program for help, will you also include his mother and myself in on what you're doing with him?

Variety of modes
of treatment:

13. I need help with my problems but group therapy does not seem to do me much good. Do you offer anything else?

Variety of modes
of treatment:

14. I need help but it seems as though every place I go they say I have to take medication. Can I come to your place and be treated without medication?

Adult Service
Child Service

My son who is eight says old is having a lot of emotional problems. Can he get treated in your program without medication?



Scenarios (Cont'd)

How complaints
are handled:

15. If I wanted to talk to someone about how my girl-friend is treated at your place, who would I talk to?

Entry requirements:

16. I live in _____ (city in part of district other than one called) and I work in _____ (district called). I want to see someone in this area as it is closer to work. Can I?

Confidentiality:

17. Can I come into your program to see a therapist without having to fill out papers and things? I don't want any record of my coming there. Can my boss or wife find out if I come to your place for help with my problems?

Accessibility for
the physically
handicapped:

18. Is it possible to get to your place if I'm in a wheelchair? If not what do you suggest?



C O N F I D E N T I A L

SERVICE SITE NUMBER: _____
SERVICE SITE CALLED: _____
RESEARCH TEAM WORKER: _____

DATE: _____
TIME OF CALL: _____
NUMBER OF RINGS BEFORE ANSWER: _____

1. Identify script used for this phone call: _____

- a) Script appropriate for this Service Site _____
b) Script inappropriate for this Service Site _____

*2. Did you feel you were understood by Service Site staff person?

not at all a little quite a bit extremely

3. Did you feel you were treated with respect by Service Site staff person?

not at all a little quite a bit extremely

4. Would you feel comfortable calling the Service Site staff person back for the information?

not at all a little quite a bit extremely

5. Was information given you appropriate for the problem you presented?

not at all a little quite a bit extremely

6. If a referral was made, were you able to find out how to go to the agency/ person referral to?

yes _____ no _____ na(referral not made) _____

7. If referral was made, did you get a general idea of what to expect when you got to referral agency?

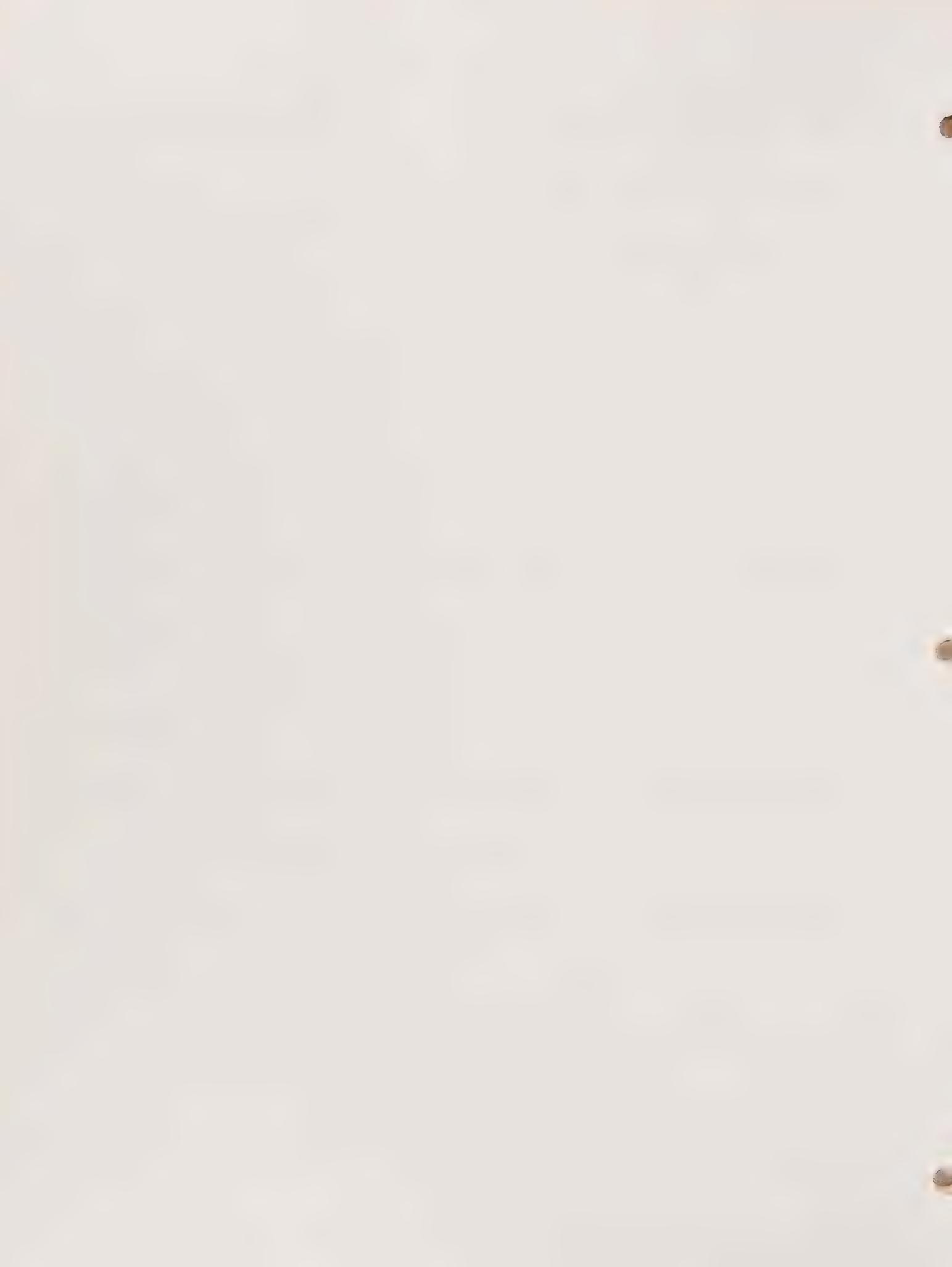
not at all a little quite a bit extremely

8. Were you responded to without unreasonable delay?

not at all a little quite a bit extremely

Other Comment: _____

* In some cases, the person who answer the calls will not be a service staff person i.e., volunteer, client, etc.



APPENDIX: CLIENT TRACKING STUDY

Objective:

To gain a sense of the quality of continuity of care process in Alameda County's County-operated and contracted mental health programs.

By: selecting in advance what are felt to be major patterns of client movement beginning at "major intake points" and studying the referrals which occur to other mental health programs in the larger County system to determine:

- the degree to which referrals are handled easily, clearly, efficiently and in a timely fashion (as known by the degree to which the referral process is recorded in case records).
- the degree to which clients actually "show up" at the next point along the line of referral and appear to "fit" there (measured by the number of re-referrals due to inappropriate referral versus the number due to having received services needed and moving on).

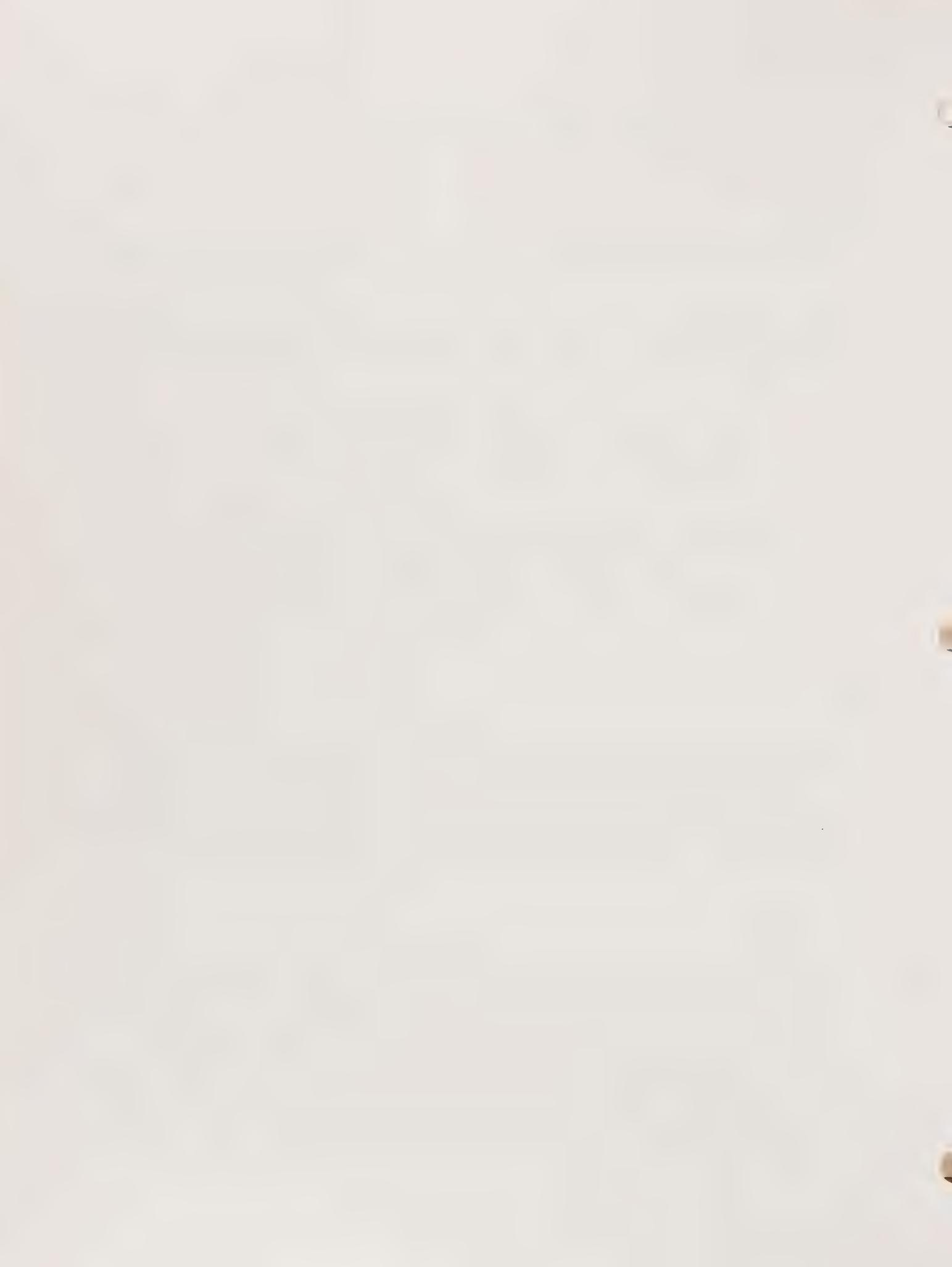
Basic question: What happened to those in our sample?

Limitations:

Results of referral did not distinguish in any way the nature of client problems presented or the degree of client cooperation as these might affect the referral process, except that records were excluded which indicated the client refused referral. The data produced by OPE client tracking might serve in a limited way as baseline data for later measuring the impact of the Agency's referral confirmation system implemented after this data was collected.

Sample Selection:

For each major intake point (program) listed below for adult clients in County-operated and contracted mental health programs, we selected up to the first 10 cases referred for primary treatment to any other County-operated or contracted mental health program (excluding concurrent referrals of clients still in program intake). Some programs (Tri-City, Valley Crisis, Asian Community Mental Health, El Centro de Salud, Suicide Prevention, Mental Health Advocates) made no referrals identifiable by our methodology during the study period. Cooperation from East Oakland Family Health Center came to late to allow inclusion into the tracking process.



Sample size for Psychiatric Emergency to outpatient program referrals was increased beyond 10 in order to test referral success to each outpatient program.

"Major Intake Programs"

Highland Psych Emergency
Fairmont Psych Emergency
East Oakland Crisis
Alameda Crisis
West Oakland Crisis
North Oakland Crisis
Central Oakland Crisis

Subsequent step programs

All "major intake programs"
Highland Inpatient Service
Napa State Hospital
Berkeley Day Treatment
Berekely Rehab
West Oakland Rehab
West Oakland Day Treatment
Central Rehab
Central Day Treatment
East Oakland Rehab
Gladman Day Treatment
Eden Rehab
Eden Day Treatment
Tri-City Rehab and Crisis
Valley Rehab and Crisis

Time Period Under Study:

October 1, 1975 to January 1, 1976.

Rationale: County-operated Crisis programs all began use of Brief Record form and log in October, 1975, thereby insuring at least this much uniformity of record-keeping and ease of access to initial sample selection by using a log which shows the disposition of a case. Secondly, study of this most recent period was intended to produce the most relevant results to current operation of programs.

Records Review:

1. At major intake programs. Highland and Fairmont Psych emergency's used the new gold sheet, sending the third copy to the program to which the client has been referred. East Oakland, Alameda, Central Tri-City, Valley and Eden Crisis programs all use the Brief Record in the same manner.
2. Records reviewed at subsequent steps in tracking were those kept for the client whose progress was followed.

Instruments Used:

(See attached Client Tracking Record Review forms - one for program of initial contact, another for program of subsequent contact.)

Interpretation of Results:

The amount of usable data fell short of our expectations, primarily because of the lack of uniformity in case recording practices. Thus, results are reported only where meaningful, at the site level (Volume III) in a contract including both kind and members of referrals and at the systemic level (Volume II) only as a single aggregate figure of referral success from the first to second step of referral. For these reasons (and considerations of space), a complete description is not reported in this Appendix of site by site referral data. OPE will provide this on request from any given program, if required.

It is anticipated that the Agency's referral confirmation system will provide a more sophisticated means for evaluating continuity in future evaluations.

CLIENT TRACKING RECORD REVIEW FORM
PROGRAM OF INITIAL CONTACT

Date: _____ Program: _____ BY: _____

ID INFO
Client: _____ file #: _____

Date of first contact: (phone) (in person)

_____ _____

Referral sources (only if another Co. system mental health program): _____

Previous or current treatment from Co. programs (incl this one)-- where & dates:

Treatment provided at initial contact program (thru-out referral process)

Profess. discipline of person making referral: _____

Program referred to: _____

Date of referral: _____ Time of day: _____ Day of week: _____

Date of appointment in program referred to: _____

Explanations about referral: _____

Indication of contact to program referred to:
(phone) (form or letter) (in person)

(dates) _____ _____ _____
_____ _____ _____

Indication of plan for follow-up by referring program? Yes _____ No _____

Indication of follow-through to see if referral complete? Yes _____ No _____

Subsequent contact at initial program: (problem re-referral) (confirming completion)
by:

(client) _____ _____

(referral source) _____ _____

(program referred to) _____ _____

General adequacy of this record for gaining above info: Adeq _____ not adeq. _____

Later Data:

Status of client in program referred to after: (2 weeks) (1 month)

(accepted) _____ _____

(pending) _____ _____

(referred elsewhere) _____ _____

(not seen) _____ _____

(seen, discharge without referral) _____ _____

(referred privately) _____ _____

ID INFO

Client: _____

file #: _____

Referral source: _____

Info on hand from referral source: (yes) (no)

(form or letter) _____

(notes from phone) _____

or personal contact) _____

Dates of first and subsequent contacts by: (phone) (letter) (in person)

(client) _____

(referring prog) _____

If no show, efforts made to contact: (phone-date) (mail-date) (h. visit-date)

If still no show, reason(s) why: _____

Communication back to referring program: (phone) (letter) (in person)

(dates) _____

If treated prev. in Co-system program, effort made to contact prev. therapist?

(yes) _____

(no) _____

(noted in record) _____

Treatment provided in this program through 3-month period: (type & dates)

Recommendation for care elsewhere (excluding concurrent): _____

Disposition: _____ kept in program _____ one contact, no re-referral

_____ disch, no re-referral _____ still pending

_____ referred on to: _____

date: _____ Time of day: _____ Day of week: _____

If referred elsewhere:

Profess. discipline of person making referral: _____

Date of appt. in program referred to: _____

Explanation about referral: _____

Indication of contact to program referred to:

(phone) (form or letter) (in person)
(dates)

Indication of plan for follow-up by referring program? Yes _____ No _____

Indication of follow-through to see if referral complete? Yes _____ No _____

Subsequent contact at this step: (problem re: referral) (confirming complete)
by:

(client) _____

(referral source) _____

(prog. referred to) _____

General adequacy of this record for gaining above inf: Adeq _____ not adeq. _____

Later data:

Status of client in program referred to after: (2 weeks) (1 month)

(accepted) _____

(pending) _____

(referred elsewhere) _____

(not seen) _____

(seen, discharged
without referral) _____

(referred privacy) _____

IMPACT OF ALAMEDA COUNTY MENTAL HEALTH SERVICES:

A. TREATMENT

B. CONSULTATION

Summary of Conclusions and Recommendations

A. TREATMENT

We conclude that, within modalities, extreme variance in treatment effectiveness exists among the different programs.

We recommend that the chiefs of programs falling considerable below average effectiveness for programs of similar modality explore means of increasing effectiveness with other program chiefs and a coordinator of programs of that modality.

We conclude that Day Treatment programs' produced the largest gains in functioning, followed by Crisis programs, Children's programs, and Rehabilitation programs.

We recommend that factors which systematically limit the effectiveness of treatment in all programs of a given modality be identified and corrected.

We conclude that the most impaired clients are served by the least trained clinicians, resulting in the longest, yet least effective, treatment.

We recommend that Rehabilitation services assess current clients and screen new clients in terms of amenability to treatment. Manageable clients should be assigned to paraprofessional therapists for supportive maintenance and attention to quality of life. Amenable clients should be assigned to professional therapists with treatment directed toward restoring functioning. Professional and paraprofessional staff should be given specialized and unique training for their respective roles. Client status *viz-a-viz* "treatability" should be reviewed regularly, as well as treatment goals.

We further recommend that Children's services incorporate more paraprofessionals in order to extend more services to less impaired clients.

We conclude that the relative absence of family and group treatment in all modalities, the failure to screen and evaluate new clients in Rehabilitation services, and the almost total lack of day treatment services for children reduce the impact of mental health services in Alameda County.

We recommend that service chiefs, especially in Rehabilitation and Crisis services, surmount obstacles to the provisions of family and group treatment through training and/or reallocation of personnel.

We further recommend that Rehabilitation services institute screening processes as described above.

We further recommend that the Local Mental Health Director, a coordinator of Children's services, a representative of N.I.M.H., and the chief of the Fred Finch Day Treatment program explore the limits of flexibility of that program's funding grant. The need and resources for a day treatment facility for children in South Region should be explored as a high priority.

We conclude that, as presently organized, there are no mechanisms for insuring uniformity of quality, sharing of information and resources, identifying training needs, or fostering creativity within the various programs of the same modality.

We recommend that positions of County-wide coordinators of Children's, Day Treatment, Adult Out-Patient, and Rehabilitation be created. These positions, and the



personnel filling them, must be recognized as representatives of the services being coordinated rather than as arms of central mental health administration. Their essential purpose should be to facilitate creative and effective delivery of treatment, both in County-operated and contracted programs within their modality.

We conclude that hospitalization can never be eliminated entirely, but that hospitalization is often utilized inappropriately and unnecessarily, and that hospitalization often fails to have optimal benefit for the client.

We recommend that no person who is already a patient of Alameda County Mental Health Services be hospitalized, except under clear indications of danger to self or others, unless the treating therapist has been contacted.

We further recommend that procedures be changed to reflect the need to transmit information regarding a client's hospitalization to the therapist who treats the client in the community following hospitalization.

B. CONSULTATION

We conclude that the major consumers of mental health consultation provided by Alameda County Mental Health Services are other Alameda County agencies. Furthermore, the same consultation activity may be present in several different programs with no evidence of coordination between higher administrative levels of mental health and the consumer agency. Finally, there is no reflection in the Mental Health Service's budget of the amount of service given to other County agencies.

We recommend that, in order to maximize the efficiency and effectiveness of consultation to other County agencies, the Local Mental Health Director enter negotiations with administrative heads of each other County agency which consumes a significant proportion of mental health consultation services. Those negotiations should focus on the objectives of consultation and pre-planned methods for evaluating achievement of those objectives. Consumer agencies should be charged for extensive consultation, particularly training programs.

We conclude that County agencies which potentially serve the same clients need to have knowledge of each other's resources and perspectives. Orientation of new workers in County agencies does not include sufficient orientation to other agencies. In many instances, consultation appeared to be an attempt on the part of other agencies to obtain information about mental health services.

We recommend that a resources and procedures manual for Mental Health Services be prepared for distribution to other human services agencies in Alameda County. Mental Health administration should request equivalent manuals from other agencies whose services are often needed by mental health clients.

We conclude that, second only to County service agencies, schools are the largest consumers of mental health consultation.

We recommend that the chiefs of Children's services, with the assistance of a coordinator of Children's services, explore the needs of teachers and counselors with the principals and administrators of schools in the community served. The goal of this exploration should be the development of training curricula, with measurable objectives, for school personnel.

We conclude that wide diversity exists among different programs in the proportion of community services time given to regular and continuing consultation.

We recommend that program chiefs and service modality coordinators insure that more than half of community services activity be developed into regular and continuing consultations (except when other objectives have higher priority).

We conclude that, compared with Children's services, Crisis services devote little time to consultation and lower percentages of that time to regular, continuing consultation.

We recommend that Regional Mental Health Officers confer with a coordinator of Crisis services and the chiefs of Crisis services in their respective regions to determine the needs for consultation that might be most appropriately met by Crisis services and to establish the priorities of those needs.

We conclude that most goals cited by both the consultants and consultees were consultee-centered, and relatively few program-centered goals were cited.

We recommend that a greater share of consultation services be directed at the program level.

We conclude that consultation with other County agencies tends to be less effective, as measured by our scale of overall effectiveness, than consultation with non-County agencies.

We recommend that consultation activities rated by our study as relatively less effective be closely examined by the consulting clinician, the program chief, and the consumer, especially in the case of consultation with other County agencies.

We conclude that clinicians in Alameda County Mental Health Services may lack the necessary expertise to provide highly effective consultation.

We recommend that training in consultation be provided clinicians who wish to develop particular skills in that activity.

II. Impact

The fundamental criterion for judging any human service is the impact or effectiveness of the service. Questions of cost and efficiency are meaningless unless expressed in relation to effectiveness. With no information regarding the effectiveness of a program, the planner or administrator is left with only assumptions as a guide.

Alameda County Mental Health Services have no systemmatic method of assessing the effectiveness of its services. Particular clinics utilize a variety of supervisory, peer review, or research strategies to monitor effectiveness, but the lack of consistency across programs has prohibited any comparision



of different services or modalities.

Mental Health Services can be separated into "direct" and "indirect" services. Direct services are those in which a client received treatment and/or evaluation from a therapist. Indirect services are those educational or consultative activities addressed to mental health/illness issues but not involving the provision of direct treatment by a therapist. We studied particular aspects of both direct (treatment) and indirect (consultation) services in our evaluation of the impact of mental health services.

A. TREATMENT

1. Introduction

The mental health planner or administrator needs information concerning the effectiveness of services to all clients, but limitations in the time and capacity of our evaluation led us to study only treatment of clients with "major psychiatric impairment". "*Major psychiatric impairment*" means that *disturbances in judgment, thinking, or emotions have limited a person's capacity to function in the community, a family, or at work or school*. We thus meant to exclude from our study those clients who may experience unhappiness or lack of fulfillment in life, but nevertheless, are able to perform expected social roles.

We made that decision for three reasons. First, the highest priority among the goals of the mental health service is given to treating "the most seriously dysfunctional individuals." Second, individuals who cannot function in the community become a burden on the community, and those who cannot perform family roles have detrimental effects on other family members. Third, the most seriously impaired individuals probably include those who are at greatest risk of needing to be hospitalized. Not only is hospitalization an abrupt interruption of an

individual's life in the community, it is an extremely costly service, which cost must ultimately be deducted from the total pool of funds to provide other mental health services.

We chose to identify empirically those clients with major psychiatric impairment. As an alternative, we might have chosen to study treatment of all individuals carrying particular diagnoses. It is known, however, that therapists utilize a wide variety of criteria in assigning diagnostic labels, and furthermore, a group of individuals carrying the same diagnosis may vary widely in terms of capacity to function. As another alternative, we might have chosen the clients of certain services or services modalities. Such a decision would have rested purely on assumptions, because, in fact, we did not know if the impairment levels of clients of different service modalities were significantly different. Our intention was to identify the most impaired clients in the mental health service client population, where and how those clients are being served, and to what extent clients' impairment was reduced.

2. Methodology

Stage One

In late November and early December, 1975, we asked all clinicians at all County-operated and contracted mental health services to rate *each* of their clients on the Spitzer and Endicott Global Assessment Scale (GAS)*. We also asked the clinician, through a Client Study Form, to provide some basic data on each client, including demographic data (age, gender, approximate economic condition, and living situation), treatment data (the client's

* We wish to acknowledge Doreen Rothman, Ph.D., and Patricia Heldman, M.D., along with other children's therapists who developed a revision of the Global Assessment Scale for rating children under twelve. Their contribution was extremely valuable. We especially commend clinicians whose conscientious record-keeping of client code identifiers made this study possible.

entry date into the program, the number of visits of program days of treatment to that point, the kinds of treatment provided and hours of treatment per month, and expected treatment length), and history of hospitalization (whether or not ever hospitalized, how many times, months since discharge, and whether or not the treatment plan was intended to prevent hospitalization). The data was coded so that only the clinician knew the identify of the client being rated. The Global Assessment Scale and Client Study Form are presented in the Appendices to this Volume.

Stage Two

We empirically and logically determined a cut-off point on the distribution of scores on the Global Assessment Scale for identifying those clients with "major psychiatric impairment". About one-third of all the clients were rated 40 or below on the GAS, and by definition on the scale, suffer "major impairment in several areas". These clients were thus chosen for further study.

Stage Three

We eliminated from the sample of clients who were rated 40 or below on the GAS those clients who were either hospitalized at the time of our initial assessment or who were not receiving services, even though a treatment chart might still be open in the program. We systematically selected one-half the remaining clients for reassessment in early March, 1976, a pre-post interval of approximately three months.

At the time of reassessment, we also asked the clinicians to estimate

- a. the client's level of motivation,
- b. whether the client was improving, getting worse, or stable,

- c. what degree of improvement the treatment might be expected to produce, and
- d. the highest potential level of functioning (as measured by the GAS), given the best possible outcomes of treatment and the client's history.

The Client Study Follow-up form is presented in the Appendices.

Stage Four

We selected a sample of 27 clients of Rehabilitation Services, 25 Crisis Service clients, 25 Day Treatment clients, and 18 clients of Children's Services. The clinician treating each of those 95 clients was interviewed by phone to obtain a more thorough appreciation of the client's problems, the treatment goals, resources and/or obstacles influencing progress toward those goals, and perceived value of the most recent hospitalization, both for the client and the therapist in working with the client. Our format for that telephone interview is also presented in the Appendix.

3. Findings, Conclusions and Recommendations

- a) Does the Global Assessment Scale discriminate on the bases of gender or ethnicity?

Table 1 presents comparative scores on the Global Assessment Scale for males, females, Caucasians, Blacks, clients with Spanish surname, Asian-Americans, and American Indians. We found no evidence that the GAS discriminates against any of these groups. Any instrument used to assess functioning must be free of considerations which would favor one group over another. The Global Assessment Scale seems to meet that criterion.

- b) Was our reassessment sample representative of those clients with major psychiatric impairment?

Time did not permit a reassessment of all clients identified as having major psychiatric impairment, so we decided to eliminate all clients

TABLE I

Gender and Ethnicity Comparison on the Global Assessment Scale

<u>Gender</u>	<u>Sample Size</u>	<u>Mean GAS Score</u>	<u>Standard Deviation</u>
Males	1,330	49.08	16.86
Females	1,686	51.84	16.79
<u>Ethnic Groups</u>			
Caucasians	1,882	49.71	17.12
Blacks	892	52.53	15.78
Spanish Surname	317	53.51	16.82
Asian Americans	40	47.92	21.79
American Indians	10	63.20	11.65

hospitalized at the time of initial assessment and those clients receiving no services, and to reassess half the remaining client group. Table 2 presents a comparision of the entire population of clients with major impairment, including those hopsitalized or not actively receiving treatment, with the clients who became part of our reassessment sample. There appears to be no reason to suspect that our reassessment sample differed from the larger group with major impairment in any systemmatic way.

c. How impaired is the client population of Alameda County's Mental Health Services?

Table 3 is the distribution of all client scores on the Global Assessment Scale. At the time of our assessment, there were 3,140 clients of mental health services, and we obtained GAS ratings on all but five. All but about 10% of the clients have at least "mild symptoms or some difficulty in functioning in some areas."

31.3% of the clients (985) were rated as having "major impairment in several areas," or even greater impairment and this was the group we chose for our reassessment population. Of the 985 clients who scored 40 or below on the GAS, 151 were either in the hospital or receiving no treatment, leaving a group of 834 clients. We chose half that group, 417 clients, for reassessment.

TABLE 2

Client Population with Major Impairment and Reassessment Sample

	<u>Major Impairment Population</u>	<u>Reassessment Sample</u>
1. Mean GAS Score	31.13	31.09
2. Time already in Treatment	16.78 mos.	17.84 mos.
3. Average Treatment length	25.71 mos.	29.55 mos.
4. Number of Prior Hospitalizations	4.30	3.76
5. Mean Age	34.09	34.44
6. Gender:		
Males	46.7%	46.3%
Females	51.2%	51.3%
7. Ethnicity:		
Caucasian	63.6%	60.7%
Black	23.7%	26.1%
Spanish	9.0%	7.9%
Asian	1.7%	2.4%

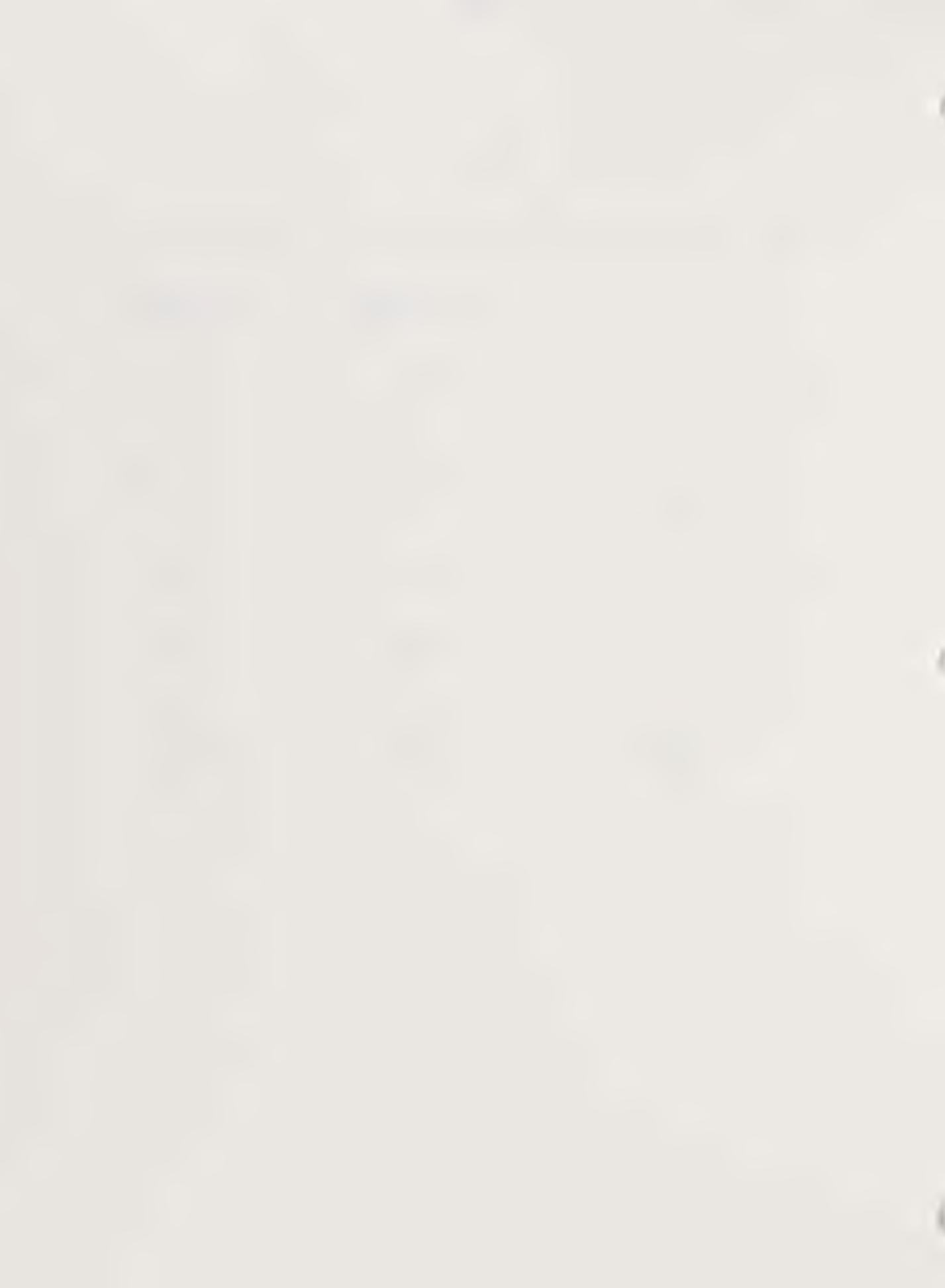


TABLE 3

Distribution of Alameda County Mental Health Service Clients on the Global Assessment Scale

<u>Number</u>	<u>Percentage</u>	<u>Cumulative Percentage</u>	<u>Scale Interval and Definition</u>
23	.73%	.73%	1 - 10: Needs constant supervision
78	2.5%	3.23%	11 - 20: Needs some supervision
261	8.3%	11.53%	21 - 30: Unable to function in almost all areas
623	19.8%	31.3%	31 - 40: Major impairment in several areas
462	14.7%	46.0%	41 - 50: Serious symptomatology or impairment in functioning
726	23.1%	69.1%	51 - 60: Moderate symptoms or generally functioning with some difficulty
646	20.6%	89.7%	61 - 70: Mild symptoms or some difficulty in functioning in some areas
226	7.2%	96.9%	71 - 80: Minimal symptoms, no more than slight impairment in functioning
88	2.8%	99.7%	81 - 90: Transient symptoms, good functioning in all areas
2	0.1%	99.8%	91 - 100: No symptoms, superior functioning
5	.2%		Missing data
3,140			



- d) How effective were the various programs and modalities in raising the functional level of a sample of their clients with major psychiatric impairment?

WE CONCLUDE that within modalities, extreme variance in treatment effectiveness exists among the different programs.

WE RECOMMEND that the chiefs of programs falling considerably below the average effectiveness for programs of similar modality should explore means of increasing effectiveness with other program chiefs and a coordinator of programs of that modality.

SUPPORT: (see Table 4)

Within Rehabilitation Programs, the range is from 1.84 points to 10.00 points.

Within Crisis Programs, the range is from 2.79 points to 21.60 points.

Within Day Treatment Programs, the range is from 1.00 points to 16.08 points.

Within Children's Programs, the range is from -3.00 points to 14.75 points.

WE CONCLUDE that Day Treatment Programs produced the largest gains in functioning, followed by Crisis Programs, Children's Programs, and Rehabilitation Programs.

WE RECOMMEND that factors which systematically limit the effectiveness of treatment in all programs of a given modality be identified and corrected.

SUPPORT: (see Table 4)

The average gain for a sample of 29 Day Treatment clients was 12.21 points.

The average gain for a sample of 95 Crisis clients was 9.96 points.

The average gain for a sample of 54 Children's clients was 7.63 points.

The average gain for a sample of 212 Rehabilitation clients was 6.21 points.

TABLE 4

Change in Impairment Level (Global Assessment Score) Over a Three-Month Period by Program and by Modality* for Samples of Clients with Major Psychiatric Impairment.

<u>Program</u>	<u>GAS Change</u>	<u>Sample Size</u>	<u>Clients Improved</u>	<u>Clients Worse</u>	<u>Clients No Change</u>
A. All Rehabilitation Programs	6.21	212	141	41	30
1. Berkeley Rehab	10.00	3	3	0	0
2. Central Rehab	1.84	19	6	7	6
3. East Oakland Rehab	6.19	58	37	16	5
4. Alameda Rehab	3.89	9	8	0	1
5. Eden Rehab	8.57	14	7	5	2
6. Tri-City Rehab	6.10	29	20	5	4
7. Valley Rehab	8.17	12	10	0	2
8. CCSS, Hayward	6.85	48	36	6	6
9. North Oakland Rehab	6.70	20	14	2	4
B. All Crisis/Adult Out-Patient Programs	9.96	95	71	11	18
10. Central Crisis	12.27	15	14	1	0
11. East Oakland Crisis	6.28	18	10	3	5
12. Alameda Crisis	10.00	7	4	1	2
13. Eden Crisis	21.60	5	4	1	0
14. Tri-City Crisis	10.06	16	10	3	3
15. Valley Crisis	12.71	7	5	0	2

* El Centro de Salud Mental, East Oakland Health Alliance, and some Children's programs see both adult and juvenile clients. For modality totals, the adult clients were combined with Crisis services and the juvenile clients were combined with Children's services. Thus, for Children's and Crisis services, the modality sample size is not equal to the sum of the samples from each of the programs listed under those modalities.



Table 4 (cont'd)

<u>Program</u>	<u>GAS Change</u>	<u>Sample Size</u>	<u>Clients Improved</u>	<u>Clients Worse</u>	<u>Clients No Change</u>
B. <u>All Crisis/Adult Out/Patient Programs (Cont'd)</u>					
16. El Centro de Salud Mental	15.40	5	5	0	0
17. East Oakland Health Alliance	12.71	7	6	0	1
18. North Oakland Crisis(W.O.H.C.)	14.50	6	5	0	1
19. West Oakland Crisis(W.O.H.C.)	2.79	14	8	2	4
C. <u>All Day Treatment Programs</u>	<u>12.21</u>	<u>29</u>	<u>24</u>	<u>3</u>	<u>2</u>
20. Berkeley Day Treatment	9.67	3	2	1	0
21. Central Day Treatment	15.12	8	8	0	0
22. Gladman Day Treatment	1.00	4	1	2	1
23. Eden Day Treatment	16.08	12	11	0	1
24. North Oakland Day Treatment (W.O.H.C.)	3.5	2	2	0	0
D. <u>All Children's Programs</u>	<u>7.63</u>	<u>54</u>	<u>33</u>	<u>4</u>	<u>12</u>
25. Central Child Development Service	14.75	8	7	0	1
26. Alameda Children's Service	-3.00	3	2	1	0
27. Eden Children's Service	3.72	25	13	3	9
28. Tri-City Children's Service	12.12	8	7	0	1
29. Valley Children's Service	10.50	4	4	0	0
30. Probation Guidance Clinic	0.00	1	0	0	1



- e) Is there a relationship between client impairment, service, and effectiveness among the different service modalities?*

WE CONCLUDE that the most impaired clients are served by the least trained clinicians, resulting in the longest, yet least effective treatment.

WE RECOMMEND (1) *that Rehabilitation Services assess its current clients and screen new clients in terms of amenability to treatment. Unamenable clients should be assigned to paraprofessional therapists for supportive maintenance and attention to quality of life. Amenable clients should be assigned to professional therapists with treatment directed toward restoring functioning. Professional and paraprofessional staff should be given specialized and unique training for their respective roles. Client status viz-a-viz "treatability" should be reviewed regularly, as well as treatment goals.*

(2) *that Children's Services should incorporate more paraprofessionals in order to extend more services to less impaired clients.*

SUPPORT:

Table 5 shows that the clients of Rehab Services have the lowest mean GAS score and clinician-rated level of motivation of the four modalities. A greater percentage of clients have been hospitalized, and less improvement is expected as a result of treatment. The therapist-rated client potential (on the GAS) for the reassessment sample was not substantially different from current levels of functioning.

With the exception of Day Treatment Services, which provide treatment in teams, Rehabilitation Services has the highest ratio of paraprofessional to professional staff. Children's Services, with seven more professionals than Rehab, has only eight paraprofessionals compared with 30 in Rehab. The client-to-staff ratio in Rehab is the highest of the four modalities, almost twice that of Children's Services (see Table 6).

* For modality comparisons, County-operated and contracted services were combined. The juvenile clients of El Centro de Salud Mental and East Oakland Health Alliance were regarded as being in Children's Services, the adult clients as part of Crisis Services. Fred Finch, Lincoln Child Care, Ann Martin, and EBAC clients were not combined with Children's Services. Clients at CCSS in Hayward were included with Rehab Service.



TABLE 5

Comparisons Between Service Modalities: Clients.

	<u>Rehab</u>	<u>Crisis</u>	<u>Day Rx.</u>	<u>Childrens</u>
1. Number	1,221	1,260	165	420
2. Mean GAS Score (Standard Deviation)	47.21 (17.69)	55.21 (15.02)	48.76 (15.42)	50.34 (17.01)
3. Clients with prior hospitalization	870 (71%)	226 (18%)	107 (65%)	12 (3%)
4. Mean number of hospitalizations	4.33	3.53	4.63	2.42
5. Clients' Motivation*	2.38	2.75	3.04	2.72
6. Clients' Prognosis**	2.60	3.05	3.46	2.79
7. Clients' Potential GAS (Standard Deviation)***	46.55 (15.32)	56.03 (13.80)	56.45 (14.47)	54.09 (18.89)

* On the following scale:

- 1 - Not at all
- 2 - Very little
- 3 - Somewhat
- 4 - Very

Data is from reassessment sample only (N=405)

** On the following scale:

- 1 - Expect no significant improvement
- 2 - Expect very little improvement
- 3 - Expect some improvement
- 4 - Expect considerable improvement

Data is from reassessment sample only (N=405)

***If the standard deviation of a distribution is added to and subtracted from the mean of that distribution, the resulting range will include about 68 percent of all the scores in that distribution.



TABLE 6

Comparisons Between Service Modalities: Service and Outcomes

<u>SERVICE</u>	<u>Rehab</u>	<u>Crisis</u>	<u>Day Rx.</u>	<u>Children's</u>
1. Professional Staff	30	50	13	37
2. Paraprofessional Staff	30	30	25	8
3. Clients-to-Staff Ratio	20.35	15.75	4.34	11.77*
4. Average Treatment Length**	32.40 mos.	13.96 mos.	9.10 mos.	12.05 mos.
5. Percentage of Clients with "Indefinite" Treatment	32%	6%	0.6%	2%
6. Mean Treatment hours/Month for Reassessed Clients	13.49	4.26	74.21	4.87
7. Supportive Maintenance is a Treatment Goal***	33%	12%	25%	6%
8. Prevent Hospitalization is a Treatment Goal	26%	4%	24%	6%
<u>OUTCOMES</u>				
1. Mean GAS Change (Standard Deviation)	6.21 (12.45)	9.96 (13.07)	12.21 (13.79)	7.63 (11.20)
2. Percentage of Reassessed Clients Still in Treatment	80.2%	52.6%	44.8%	59.3%
3. Percentage of Reassessed Hospitalized Since Initial Assessment	7.6%	4.3%	7.4%	0%
4. Percent of Reassessed Clients:				
"Getting Worse"	9.0%	7.4%	6.9%	5.6%
"Stable"	55.2%	33.7%	24.1%	40.7%
"Improving"	26.4%	33.7%	41.4%	42.6%
"Don't Know"	9.4%	25.3%	27.6%	11.1%

* Excluding the Probation Guidance Clinic which has treatment as a low priority.
 "In Children's Services, the entire family may receive treatment although only one chart, in the child's name, may be opened".

** Obtained by adding time already in treatment and expected additional treatment

*** From interviews with clinicians.

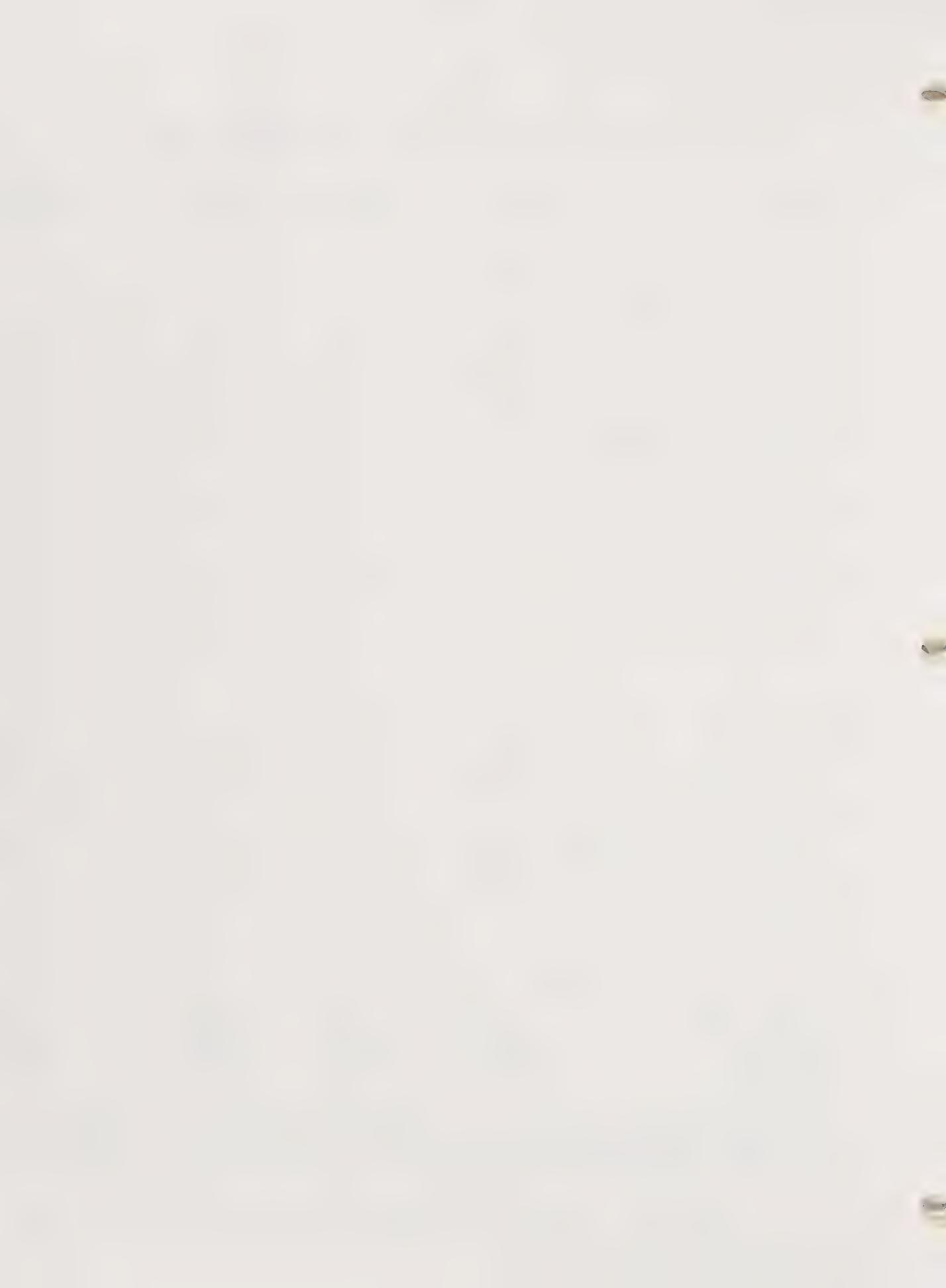


TABLE 7

Correlates with Change in Global Assessment Score by Service Modalities.

	<u>Rehab</u>	<u>Crisis</u>	<u>Day Rx</u>	<u>Children's</u>
1. Hours of Treatment Per Month	.01 (N=212)	.25 (N=95)	.25 (N=29)	-.28 (N=54)
2. Initial GAS Rating	-.19 (N=212)	-.08 (N=95)	-.50 (N=29)	.26 (N=54)
3. Time in Treatment	.05 (N=212)	-.18 (N=95)	-.08 (N=26)	-.05 (N=54)
4. Client's Motivation*	.28 (N=204)	.60 (N=84)	.55 (N=26)	.47 (N=50)
5. Client's Prognosis	.23 (N=206)	.41 (N=91)	.50 (N=28)	.58 (N=53)
6. Client's Potential*	.53 (N=212)	.71 (N=95)	.38 (N=29)	.56 (N=54)

* As rated by the client's therapist.

Also from Table 6 we see that 55% of Rehab's clients are "stable," far higher than other modalities, and that 32% are expected to be in treatment "indefinitely." "Supportive maintenance" was cited as a treatment goal in 33% of those cases whose clinician we interviewed, substantially higher than for other modalities. Average treatment length in a Rehab Service is 32.40 months, twice that of Crisis Services and more than three times the treatment length in Day Treatment, in spite of the fact that the initial GAS scores for Rehab and Day Treatment were very similar.

Finally, Table 6 presents GAS change data from our study. 80.2% of the clients to be reassessed were still in treatment with Rehab Services, and those clients had gained 6.12 points on the Global Assessment Scale. In contrast, 44.8% of Day Treatment's clients were still in treatment and had gained 12.21 points on the GAS. About 7.5% of the reassessment sample in both Rehab and Day Treatment modalities had been rehospitalized at some time since the initial assessment. Only 26.4% of Rehab's clients were seen by their therapists as "improving," the lowest percentage of the four modalities.

We were told by professional therapists in Rehab services that their caseloads were so filled with chronic clients who could not be helped substantially that they had little time to serve those who could be helped. Correspondingly, our telephone interviews with therapists left us with the impression that paraprofessional staff were often faced with treatment problems which were far beyond their competence.

Table II-7 presents several correlates with GAS change. The extent to which a client showed gain in functional level over time was found to be more closely related to therapist's appraisal of the client's prognosis, motivation to change, and potential level of functioning than to the initial level of impairment or the duration or intensity of treatment.

Discussion

Given our present division of direct mental health services into modalities, Rehabilitation Services appears to be used as the "dumping ground" for the older client, coming from a State hospital,

with, in most cases, an extensive history of prior hospitalizations. Such "chronic" clients are generally regarded as untreatable, and paraprofessional staff are disproportionately allocated to Rehab Services, reserving better trained staff for other services whose clients are thought to be more treatable.

We speculate that one pattern of client involvement with the mental health services system is as follows:

When an adult client first appears for services, he is seen as an outpatient at a Crisis Service, and he is usually treated by a professional therapist. If the client's condition worsens, he may be transferred to a Day Treatment Service, where he is treated by a treatment team consisting of both professional and paraprofessional therapists. Or, if the client is hospitalized, he may be referred to a Day Treatment Service following discharge from the hospital, especially if the hospitalization reflected a "first break" psychotic experience. If the client is hospitalized in the future, the likelihood is that he will be referred this time to a Rehabilitation Service where he will be treated by a staff which is largely paraprofessional and where the treatment goals are likely to be "maintenance and support," based on an assumption of "chronicity." Thus, "chronicity" describes both a pattern of services, service providers, and progressively modest treatment goals as well as a hospitalization history.

A very safe conclusion would be that some clients with extensive hospitalization history and referred to Rehabilitation Services are amenable to psychotherapeutic treatment and some are not. We found no evidence that Rehab Services systemmatically evaluate the treatment potential of each new client and assign that client to a professional or paraprofessional therapist on the basis of treatability. Instead, we found both professional and paraprofessional therapists working



with highly impaired clients, some clearly treatable (especially when pathological family relationships were identified as blocking the development of better functioning), and some not (patients with severe neurological damage and 20 or more years residence in a State hospital).

We reaffirm that every client has the right to as much treatment as can benefit that client; at the same time, we feel that it is pointless for a mental health service to expect to bring every client to the highest levels of functioning. Mental health can, and should, work toward the highest quality of life for every client, and for clients with limited potential, this may simply mean greater independence and autonomy, opportunity for socialization and recreation, and some opportunity for interpersonal relationships. These goals are within the grasp of the paraprofessional therapist, especially with training focused on those activities rather than more sophisticated training in psychodynamics and treatment techniques. By the same token, every client who has the potential to regain a fully functional life should have access to a professionally trained therapist to assist him in that effort. Furthermore, we feel that decisions regarding a client's potential are too important to be entrusted to the therapist who is assigned to the client on a random basis. For those reasons, we recommend that Rehabilitation Services develop and implement a systematic procedure for the assessment and assignment of every new client with frequent and regular reviews of that assignment.



In contrast, Children's Services are a "gold mine" of highly trained staff with very few paraprofessionals who serve all children and their families, regardless of level of impairment. We were struck by the capability of Berkeley's Family, Youth, and Children's Center to provide service for a great number of clients in a great variety of styles. That capability is made possible by a structure of a small number of professional staff who supervise a large number of students and other paraprofessionals. Not only is that service able to provide an enormous amount of direct treatment, they also offer an astonishing variety of workshops, drop-in groups, and seminars to high-risk groups in the community. The program even advertises its offerings to every household in Berkeley by attaching a brochure to the City's garbage bill! While the quality of supervision must be safe-guarded, and while enough professional staff time must be reserved for those clients whose problems are beyond the capacity of the paraprofessional, we encourage Children's Services to borrow from Berkeley's model wherever possible.

- f) Are there gaps in the treatment continuum which result in less than optimal treatment?

WE CONCLUDE that the relative absence of family and group treatment in all modalities, the failure to thoroughly screen and evaluate new clients in Rehab Services, and the almost total lack of day treatment services for children reduce the impact of mental health services in this County.

- WE RECOMMEND (1) that service chiefs, especially in Rehab and Crisis Services, surmount obstacles to the provision of family and group treatment through training and/or reallocation of personnel.
- (2) that Rehab Services institute screening processes as described above.
- (3) that the local mental health director, a coordinator of Children's Services, a representative of N.I.M.H., and the chief of the Fred Finch Day Treatment Program explore the limits of flexibility of that program's funding grant. The need and resources for a day treatment facility for children in South Region should be explored as a high priority.

SUPPORT:

Only 11.4% of Rehab clients are provided a diagnostic evaluation by Rehab Services. Other parts of our evaluation found that records of hospitalization are often poor or not available so that re-evaluation becomes very desirable, yet is seldom done.

Only 7.4% of Rehab's clients receive family treatment inspite of the fact that in our interviews with Rehab clinicians, family problems were mentioned with regard to 14 of the 27 clients studied.

Only 8.5% of clients of Crisis Services receive family treatment despite the fact that in our interviews with Crisis clinicians, family problems were mentioned with regard to 7 of the 25 clients studied.

Only 16.9% of the clients of all services receive group treatment.

Therapists in every Children's Service in which we conducted interviews mentioned the acute need for day treatment facilities for children and adolescents. If a child needs more than outpatient treatment, he must go to a hospital or else enter the Probation or Welfare Systems as a ward. Either of these alternatives shuts off the possibility of continuing to work with the child and the family in the community, and the child is now a client in another agency.



with therapeutic value, and that group treatment is the treatment mode of choice for some clients. If a service offers no group therapy, the client is less than optimally served. Furthermore, both modes (family and group) are ways of treating several clients simultaneously, thereby increasing the productivity of a service.

In a different vein, our evaluation makes it clear that mental health services to children are given much lower priority than services to adults. There are 178 therapists for adults in Alameda County and 45 therapists for children. There are five day treatment centers for adults and only one for children (To be sure, schools have counselors, but then, so do many businesses where this County's adults are employed.).

We feel that the need for children's day treatment services in both North and South Regions is imperative. If the Fred Finch Program can be expanded to include children from outside the East Oakland catchment area, one part of the problem may be partially solved for North Region, at least. If Children's Services follow our recommendation above and incorporate more paraprofessionals, perhaps some of the present professional staff might be free to provide day treatment services in South Region. Given the imbalance between staff for children and those for adults, however, we would rather see additional staff allocated to fill this severe need.

g) How could supportive functions better serve the delivery of treatment?

WE CONCLUDE that as presently organized, there are no mechanisms for insuring uniformity of quality, sharing of information and resources, identifying training needs or fostering creativity within the various programs of the same modality.



WE RECOMMEND that positions of County-wide coordinators of Children's, Day Treatment, Adult Outpatient, and Rehabilitation be created. These positions, and the personnel filling them, must be recognized as representatives of the services being coordinated rather than as arms of central mental health administration. Their essential purpose should be to facilitate creative and effective delivery of treatment, both in County-operated and contracted programs within their modality.

SUPPORT:

We found tremendous diversity among services of the same modality. For example, 26.3% of the clients in one Rehab service receive medication; in another Rehab program, 81.1% of the clients are medicated. In one Children's program, 41% of the clients receive family therapy, compared with 74.5% in another children's service. The average treatment length in one Crisis Service is 3.98 months; in another Crisis Program, that figure is 23.34 months.

The focus of two programs within the same modality may be very different. One Day Treatment Program attempts to serve clients who might otherwise be hospitalized. Another directs its major efforts to clients who are at the point of leaving the hospital. We found evidence that communication among the chiefs and staffs of different programs within the same modality is virtually non-existent.

As the mental health service moves further toward regionalization and the community mental health center model, it will become more difficult to identify and justify training needs for particular modalities. A modality coordinator would be able to recognize needs for training shared by the several services of the same modality and to develop training programs to meet those needs.

The County has always faced the problem of who should monitor contracted programs. We feel that effective monitoring can only be performed by someone who possesses expertise in the area of service performed by the contractor. Furthermore, contractors and County-operators, alike, have at times felt disenfranchised or unfairly compared. A modality coordinator would be in a position to monitor all programs of a given modality, whether County-operated or contracted.



Many modalities have to cope with constantly changing regulations of other agencies. For example, policies affecting the admission of juveniles to Napa State Hospital have changed innumerable times in recent memory, and when that has happened, each Children's Service, independently, must pursue up-to-date information. A modality coordinator could, and should, be a source of timely information relevant to the operation of that modality.

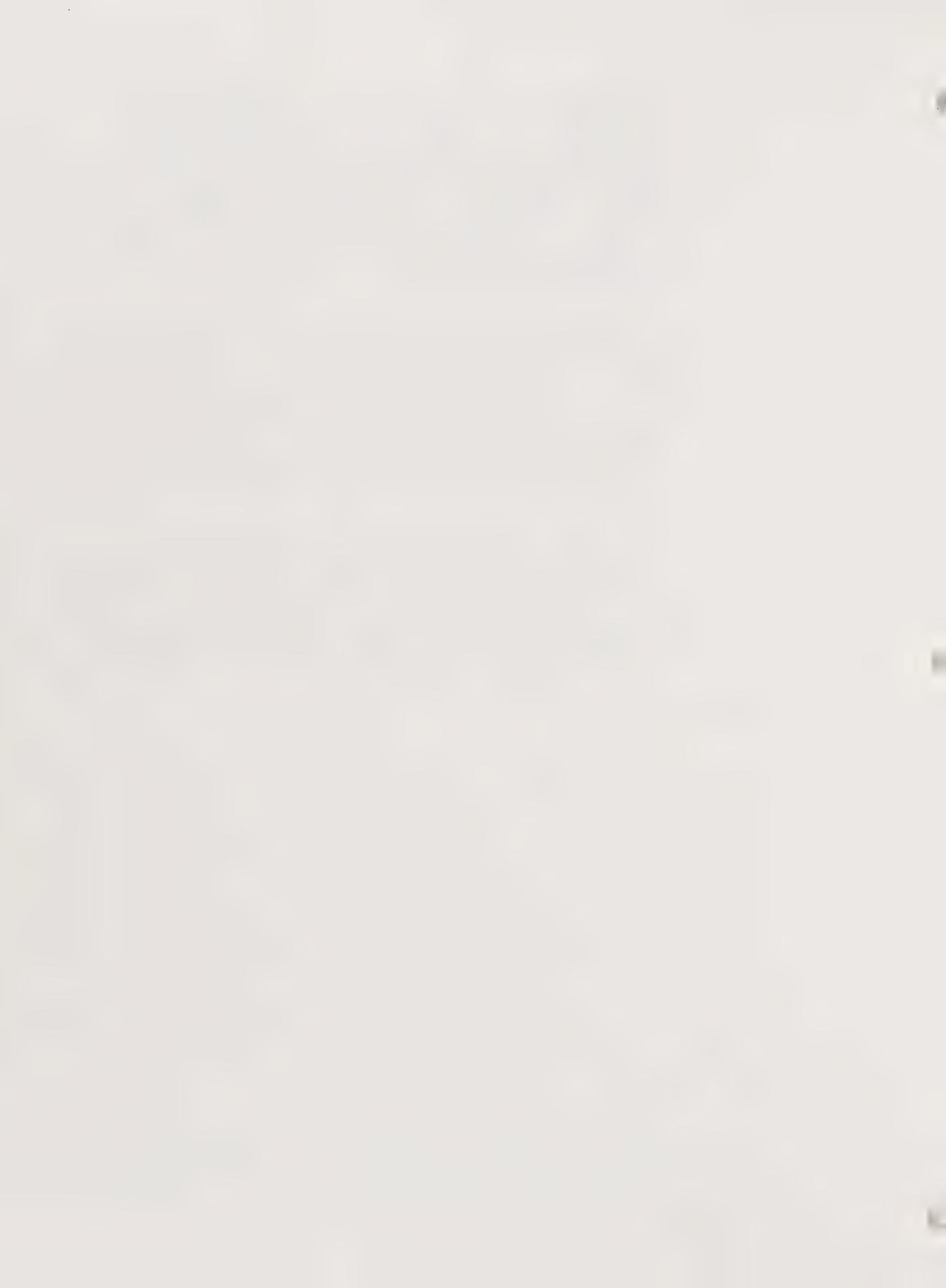
We found numerous examples of the need for coordination of the workers of different agencies. The most notable example is that of Rehabilitation Services and the State's Continuing Care Services Section (CCSS). The fact that there is no uniform policy relating those two services across the County is testimony to the need for a coordinator's position to be filled by someone dedicated to solving the problems of service delivery for that modality.

Even if the County moves totally in the direction of the community mental health center model, there will always be functions which resemble our present children's, day treatment, outpatient, and rehabilitation modalities. Centralized services include planning and evaluation components, but those components cannot be expected to stimulate creative service delivery for all four functions.

Discussion

The pendulum of organizations perpetually swings between centralization and decentralization, seemingly always under the assumption that if some functions are better off centralized, then everything should be centralized, and analogously for decentralization. This County has in recent years moved from a tightly centralized structure, through a period of very decentralized services in relatively autonomous districts. Now, mental health services are divided into North and South Regions.

Some functions will always be performed more effectively at the local level, but we feel that service modalities need to be coordinated County-wide. Already, South Region is exploring the need for a



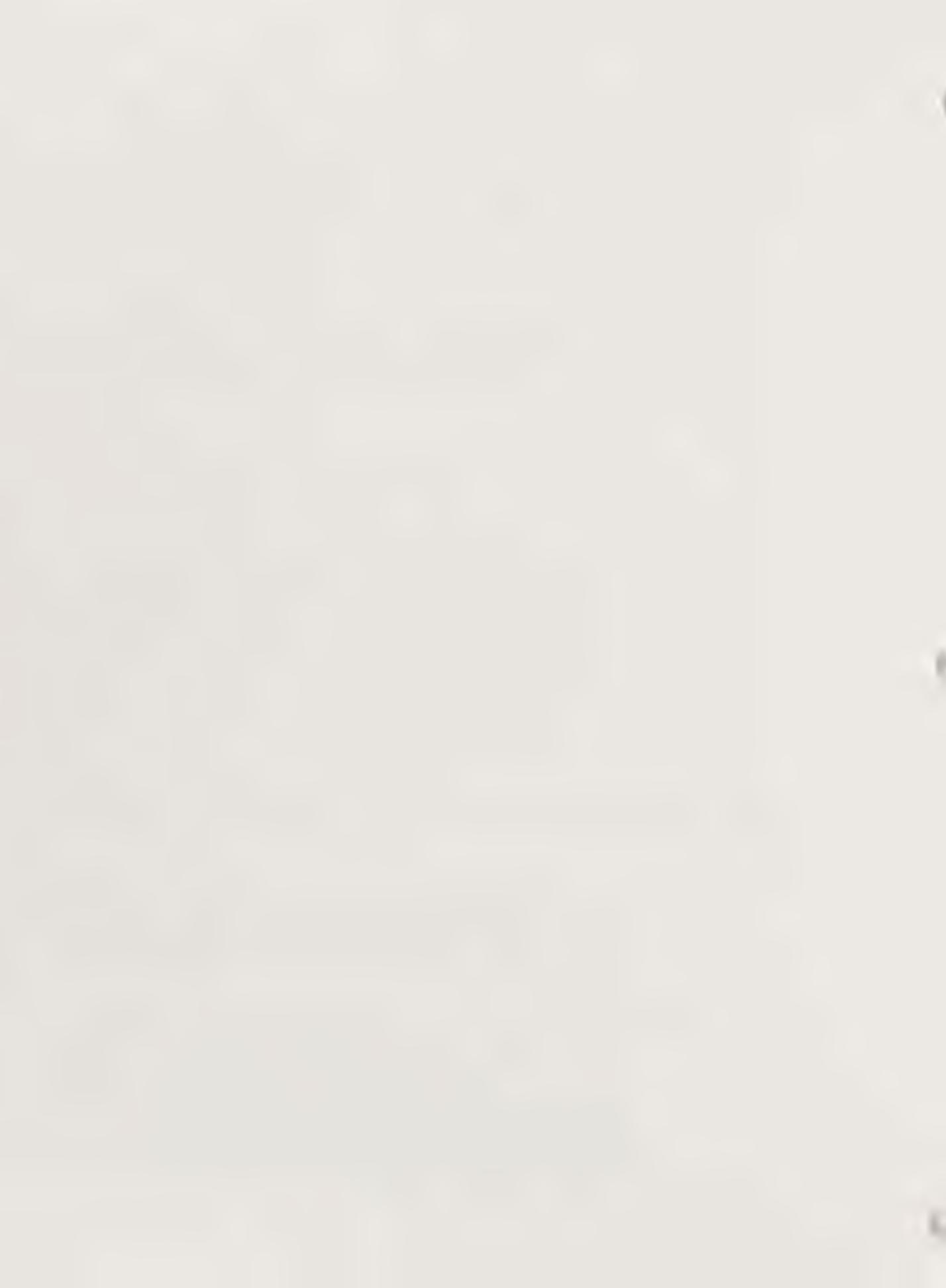
coordinator of children's services. Should North Region, with only one identified children's service (and contractors who see children as well as adults) have a "children's coordinator," and if not, how is that service to have any liaison with other children's services? Who should monitor West Oakland Health Center's Day Treatment Program? Someone who knows something about contracts, or someone who knows something about day treatment programs?

We feel that the need for centralized modality coordinators is clear and compelling, but we wish to stress that those positions have not worked well in the past, largely because they have been of little use to the line workers in those services. For that reason, it is essential that those positions be filled by persons who are approved, and perhaps even nominated, by the staff of the services they are to represent.

h) What is the role of hospitalization in the spectrum of County Mental Health Services?

WE CONCLUDE that hospitalization can never be eliminated entirely, but we found evidence that hospitalization is often utilized inappropriately and unnecessarily, and that hospitalization often fails to have optimal benefit for the client.

WE RECOMMEND that no person who is already a patient of Alameda County Mental Health Services be hospitalized, except under clear indications of danger to self or others, unless the treating therapist has been contacted. We further recommend that procedures be changed to reflect the need to transmit information regarding the hospitalization to the therapist who treats the client in the community following hospitalization.



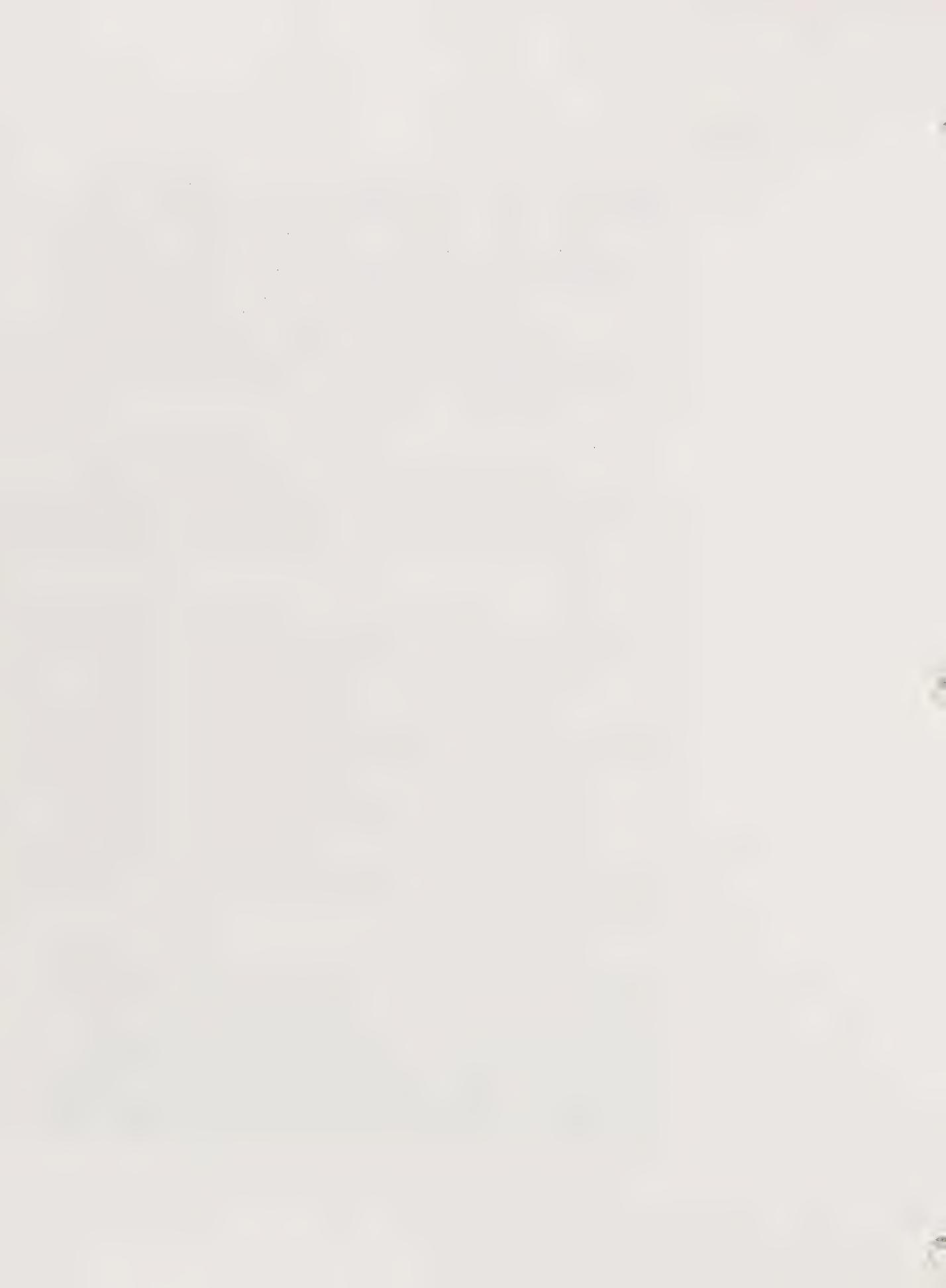
SUPPORT:

We interviewed the therapists of 95 clients with major impairment. 68 of those clients had been hospitalized. In the therapists' opinion, 34% of those hospitalizations (23 clients) could have been prevented. Family intervention and follow-up on medication were the most often cited ways in which hospitalization might have been prevented. 35% (24 clients) definitely needed to be hospitalized, in the therapists' opinion, largely because of definite suicidal or homicidal gestures or florid psychotic states. The therapists of 31% (21 clients) were uncertain as to whether hospitalization could have been prevented.

The therapists for 51% of the clients (35) were of the opinion that hospitalization had value for the client, and a high number of those cited stabilization on medication or a change in living situation as the source of that benefit. The therapists of 18% (12 clients) felt that the hospitalization had no benefit for the client, and 31% (21 clients) did not have an opinion.

The therapists of 49% of the clients (33) received useful information regarding the hospitalization from the hospital in developing a post-hospitalization treatment plan. Most of those therapists received that information through personal contact with the treating therapist at Highland Hospital's Inpatient Service. Most therapists stated that written records which accompany a patient from an inpatient service to an outpatient service in the community have little worth. Furthermore, when a patient is sent to Napa, the records from Napa are sent to the County's centralized records and must be requested by the treating program in the community. In most such instances, delays of up to four months in obtaining Napa records from Highland Central Records were reported, and in many instances, the records could never be located.

Many therapists told us that psychiatric emergency services seldom make any attempt to contact the therapist already treating a patient who is being considered for admission for inpatient treatment. One Day Treatment Service has adopted the policy of posting a current list of their patients in psychiatric emergency and a list of "stand-by" phone numbers in the event that any of the patients appear, requesting to be admitted. Clearly, this is a cumbersome procedure that not every service can be expected to follow.



Discussion

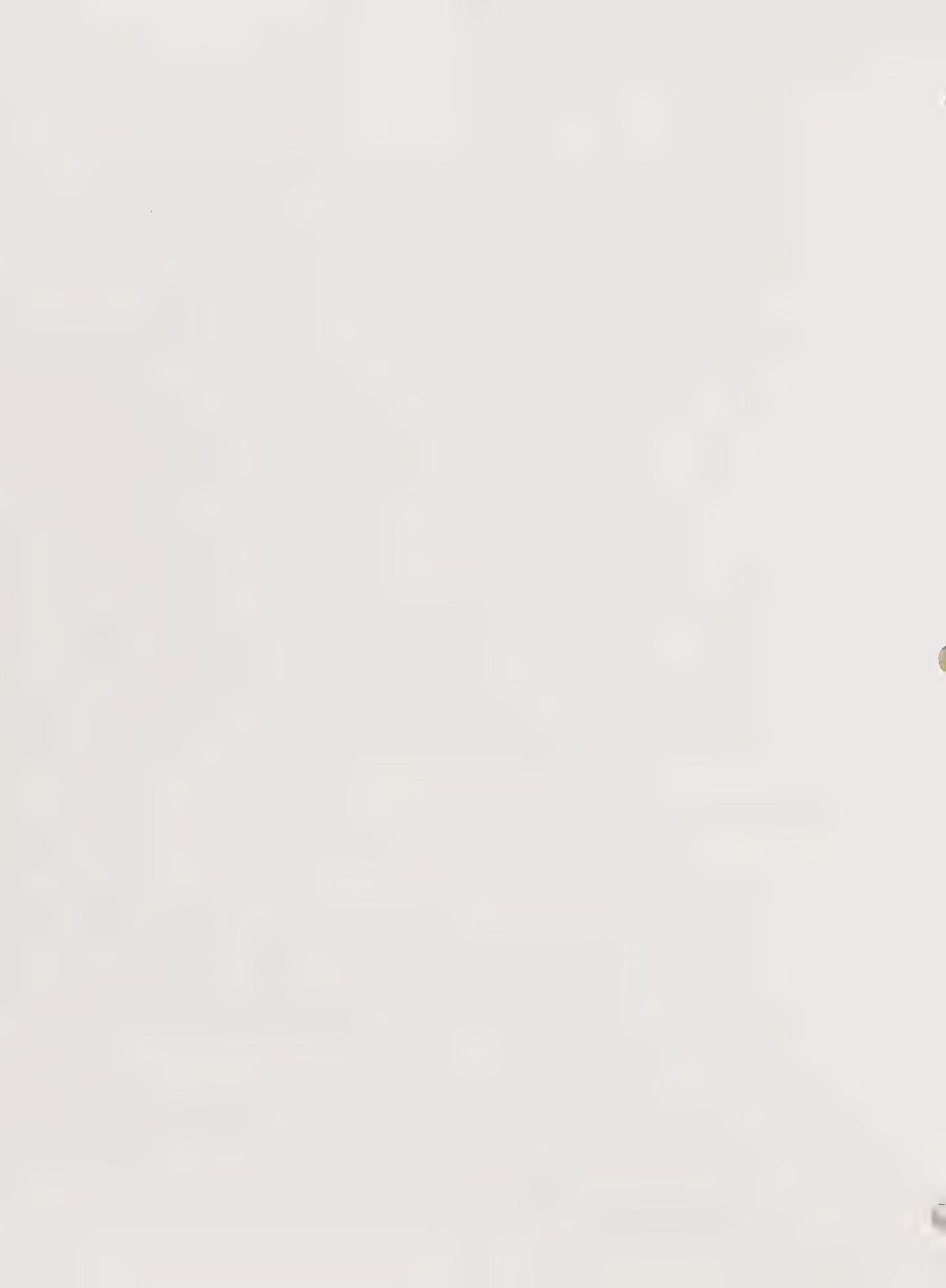
There are many reasons why clients present themselves to a psychiatric emergency service for hospitalization, or why their families bring them. The capacity to identify those patients already being treated and to contact the treating therapist demands a well-coordinated service delivery system, and Alameda County lacks such a system. Experiments at Fort Logan, Colorado and other cities have already determined that a great many clients who would otherwise have been hospitalized can be treated much more effectively in the community, but only if effective outreach teams can respond immediately and effectively to crisis situations. If this County is to reduce its present utilization of the State hospitals, it appears essential that Alameda County develop that capability, as well as procedures which make hospitalization a last alternative, and an alternative that has value, when utilized.

B. CONSULTATION

1. Introduction

The second major goal of the Alameda County Mental Health Service is "...the promotion of mental health. The target population for this goal is the entire community or communities whom we serve (1975-76 County Plan)."

A mental health service "promotes" the mental health of a community in several ways. First, it directly treats the mentally ill, and by thus reducing the prevalence of mental illness, the level of



mental health in the community is improved. Second, it fosters the early detection of mental illness. Theoretically at least, emotional disturbances which are detected early can be treated more rapidly and effectively, further reducing the prevalence of mental illness in the community. Third, population groups which are at high risk can be identified and given special surveillance and attention so that, hopefully, the incidence of mental illness among those groups may be reduced. Fourth, sources of stress can be identified as highly conducive to mental illness in any community (e.g., high unemployment, overcrowding, transiency, suburban fragmentation of the family), and those sources can be the focus of intervention by agents of mental health with the goal of reducing the incidence of mental illness.

Consultation is the activity which addresses all but the first of the above options. Through consultation, agents of other services (e.g., teachers, police, welfare workers) can be alerted to indications of mental illness at its early stages so that prompt and appropriate referrals for treatment can be made. Other services can also be alerted to the presence of high risk groups among their clientele (e.g., single parents, recently divorced) so that those groups can be given special attention.

Finally, through consultation, mental health attempts to influence sources of stress in the community which are believed to result in mental illness. For example, mental health might encourage a school system to provide extensive counseling services in a community which



has a high incidence of pregnancy among teenage, unmarried students.

Consultation has been recognized as a significant component in the community mental health center model of services. The community mental health center seeks to promote mental health, whereas the mental health "clinic" only treats those who are already mentally ill.

Consultation occurs at either of three levels. In client-centered consultation, agents of other services meet with a mental health worker to discuss the psychological significance of problems experienced by their clients and how to deal with those problems. In consultee-centered consultation, the focus is upon the agents of other services, themselves; mental health can provide training to upgrade the psychological sophistication of workers in other services, or support can be provided to workers who are experiencing stress in dealing with clients who may be mentally ill. In program-centered consultation, mental health focuses on the structure and content of another program to determine the psychological implications of what that program attempts to provide its clients.

We chose to include an assessment of consultation in our evaluation of mental health services because consultation is the means through which community mental health is promoted. We wished to determine who the consumers of mental consultation are, at what level the consultation is focused, and what impact consultation seems to have.



2. Methodology

Our evaluation of mental health consultation progressed through several stages:

Stage One: Our initial interviews at each mental health service, along with a review of recent biostatistics from all services, led us to the conclusion that consultation is a significant activity primarily in children's services, some crisis services, and in certain contracted services.* In November, 1975, a letter was sent to the chiefs and directors of those services, explaining our study, defining the kinds of consultation we wanted to study, and requesting a description of all such consultations currently active in that service. The questionnaire which accompanied the letter asked the respondent to identify the consultant and the consultees, to specify when the consultation began, how much time is given to the activity, and to define the objectives of the consultation (see Appendices).

We selected for our study only consultation activities which were regular and continuing for two reasons. First, the effectiveness of an activity can best be assessed through an examination of progress toward meeting objectives or goals. It is difficult to specify the objectives or goals of activities which are sporadic, much less to measure progress toward those goals. Second, biostatistical information already told us how much of a program's time was devoted to community services, and we wanted to determine what proportion of community services in a program was channeled into activities which are continuing, and thus, for which goals could be identified. Our letter of November, 1975 to the service chiefs and directors specified that we were only concerned with regular, continuing consultations for purposes of our study.

* Berkeley Crisis Service, El Centro de Salud Mental, East Oakland Health Alliance, Ann Martin Children's Center, Asian-American Community Mental Health

Rehabilitation and Day Treatment Services also spend considerable time in a form of consultation, namely joint planning with the operators of board-and-care and half-way houses. This activity, since it focuses on the shared client, struck us as more a part of treatment than consultation. If, however, mental health provided a curriculum of training for those operators, focused not upon particular clients



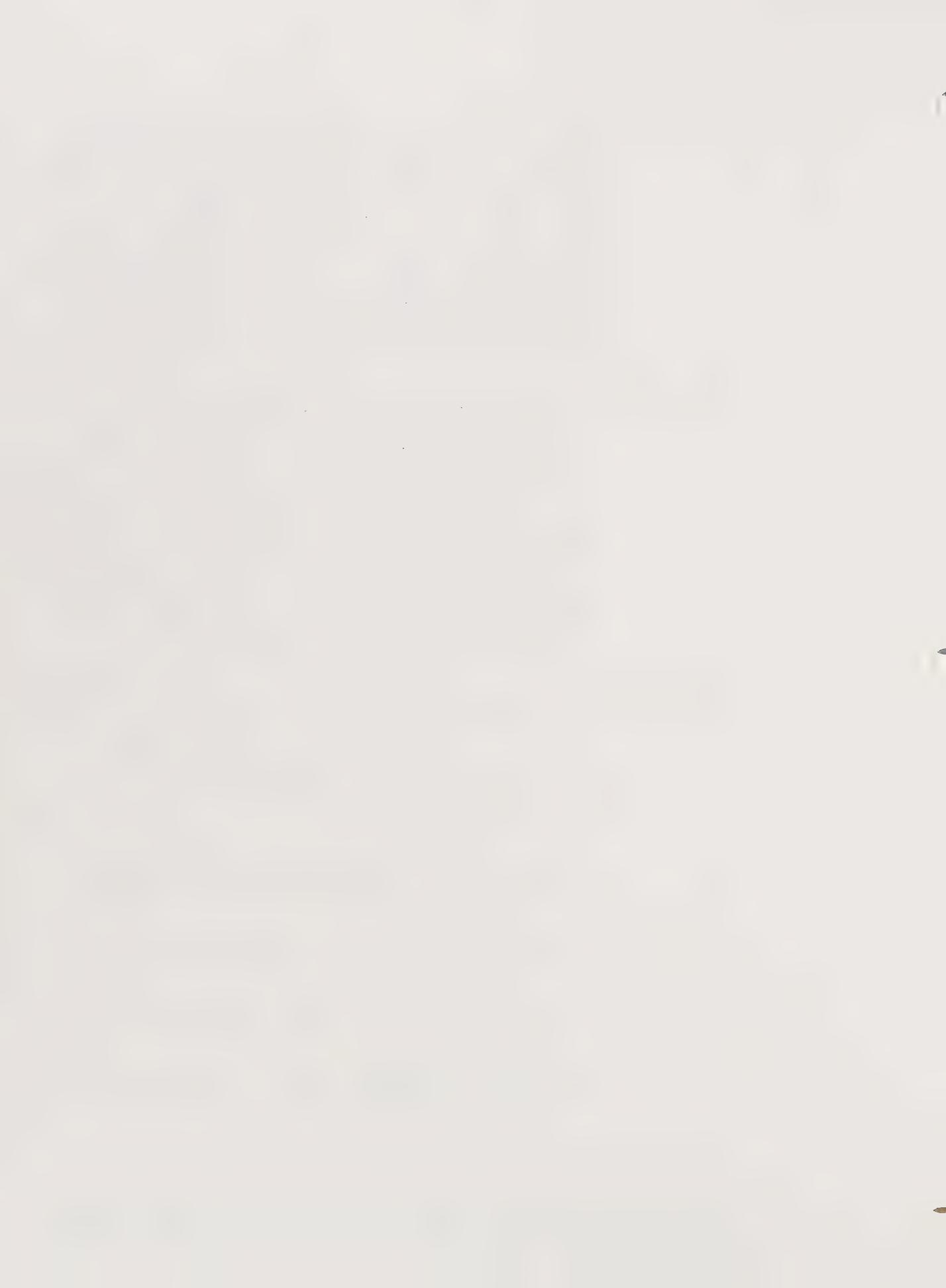
Stage Two: The consultation activities described in response to our initial questionnaire were examined closely to verify that those activities did, in fact, meet our criteria of regularity and continuity. A second questionnaire was sent in late December, 1975, to the clinician with primary responsibility for each selected consultation. This questionnaire reiterated the goals which had been specified in response to the initial questionnaire and asked the clinician to suggest some indicators he or she might use in assessing progress toward those goals (see Appendices).

Stage Three: In February, 1976, a final questionnaire was sent to the same clinicians with forms for both the clinician (consultant) and the client (consultee). This questionnaire asked both the consultant and the consultee to evaluate the consultation in terms of: (1) progress toward meeting goals, (2) satisfaction with the consultant's performance, (3) the ways the consultation time had been used, (4) the outcomes or results of the consultation, and (5) the perceived value of the consultation to both the consultant and the consultee. In addition, the consultees were asked to indicate what they felt the goals of the consultation had been (see Appendices).

Stage Four: Each consultation activity was rated on 13 five-point scales based on the following questions or criteria:

- (1) Did the consultant demonstrate an ability to translate the consultation goals into indicators of progress toward meeting those goals?
- (2) Was there congruence between the goals cited by the consultant and those specified by the consultees?
- (3) How well did the consultant feel the goals were being met?
- (4) How well did the consultees feel the goals were being met?
- (5) Was the consultant satisfied with his or her own performance?

* but upon the programs or the skills of the operators, we would readily regard such training as consultation. There may, indeed, be such programs in existence, but if so, we did not learn of them.



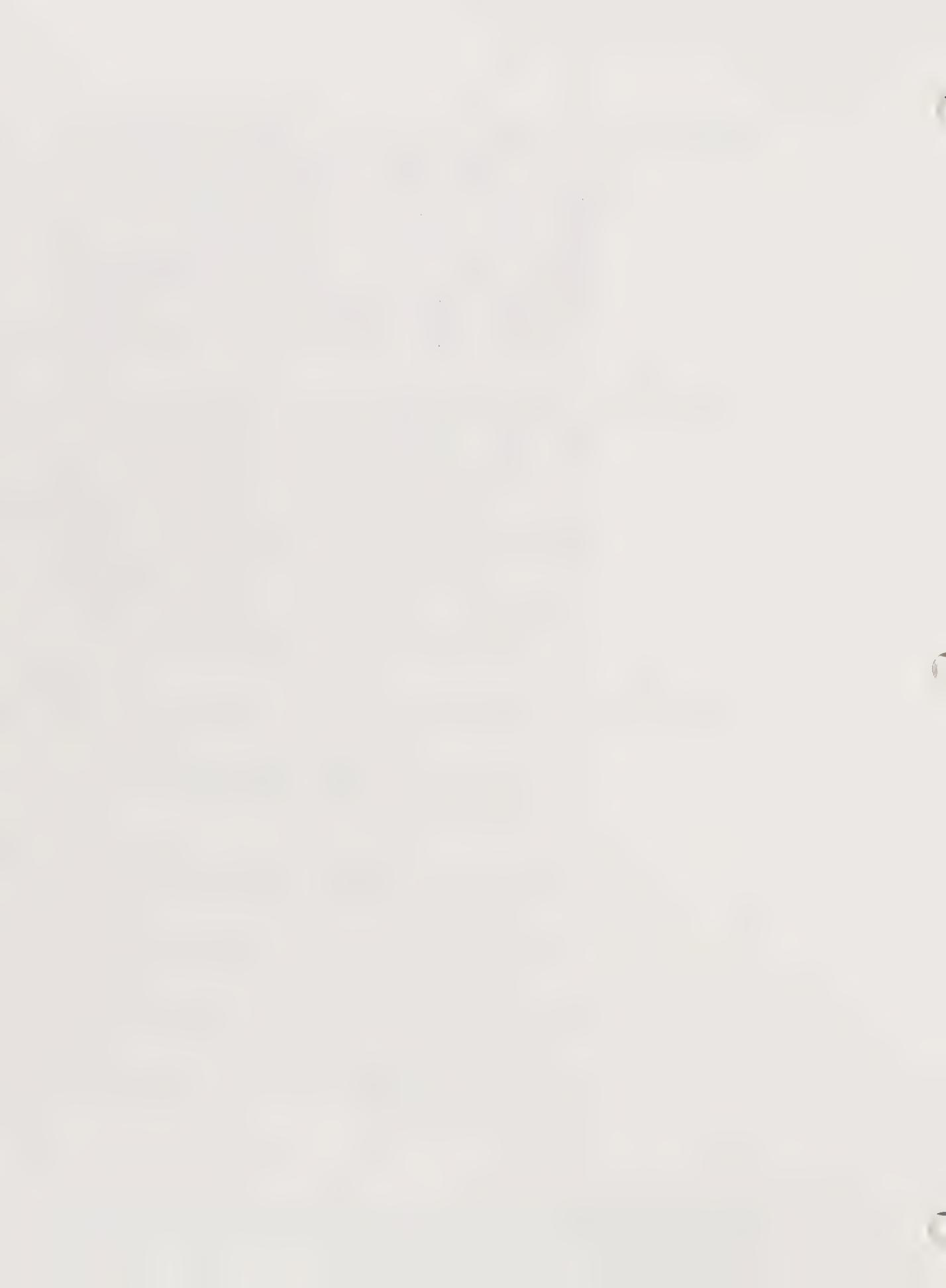
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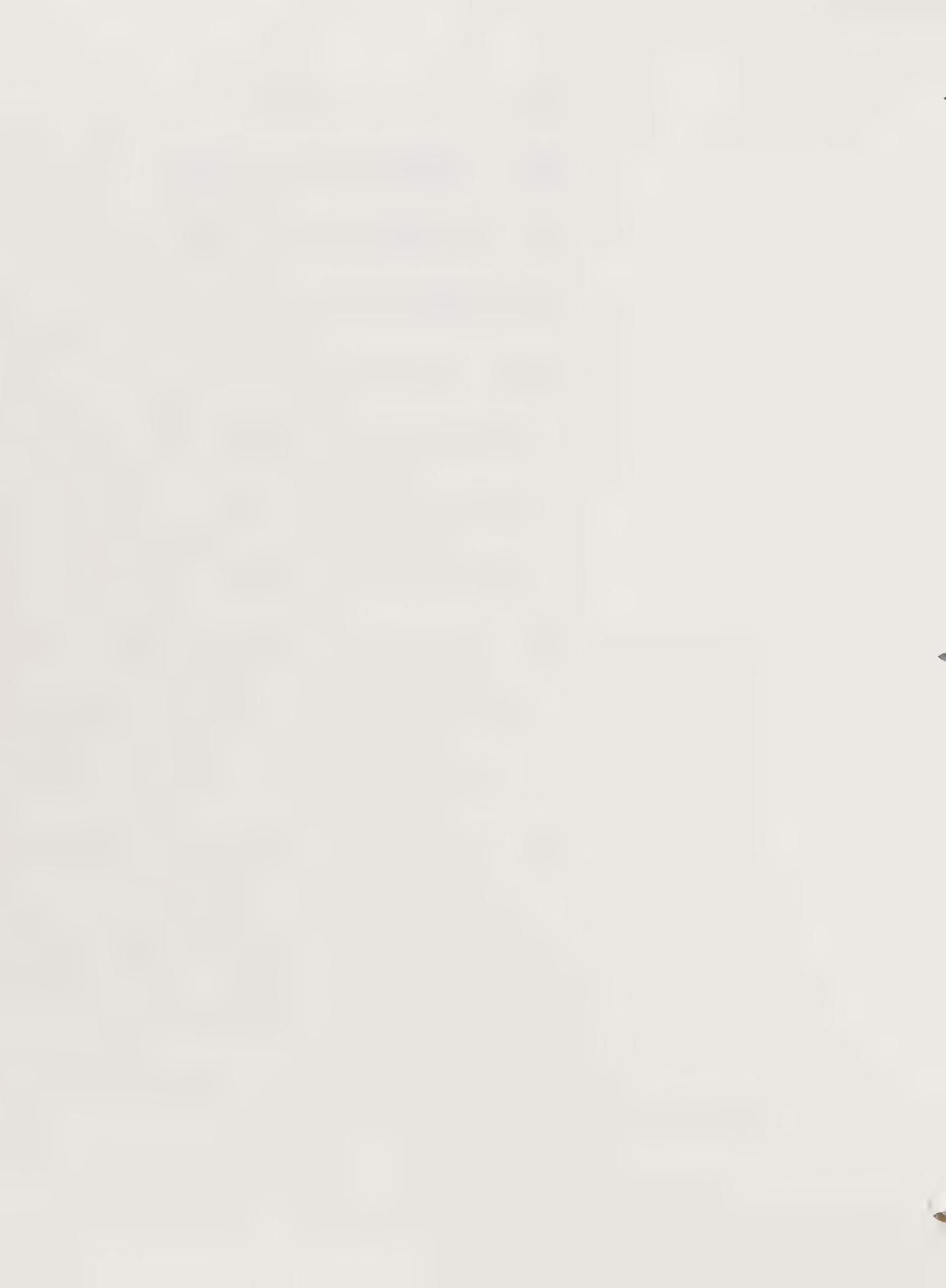
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- (2) Was there congruence between the goals cited by the consultant and those specified by the consultees?
- (3) How well did the consultant feel the goals were being met?
- (4) How well did the consultees feel the goals were being met?
- (5) Was the consultant satisfied with his or her own performance?

* but upon the programs or the skills of the operators, we would readily regard such training as consultation. There may, indeed, be such programs in existence, but if so, we did not learn of them.



- (6) Were the consultees satisfied with the consultant's performance?
- (7) Was the consultant satisfied with the ways the consultation time was used?
- (8) Were the consultees satisfied with the ways the consultation time was used?
- (9) Was the consultant satisfied with the results of the consultation?
- (10) Were the consultees satisfied with the results of the consultation?
- (11) Did the consultant see value for the consultees in the consultation?
- (12) Did the consultees see value for themselves in the consultation?
- (13) Did the consultant see value for himself or herself in the consultation?

13 five-point scales thus yielded a composite scale of overall effectiveness with a range from 13 (each scale given the lowest possible rating) to 65 (the highest possible rating on each dimension). The first two dimensions (the consultant's ability to translate goals into measurable indicators of progress, and degree of congruence between the consultant's goals and those expressed by the consultees) were rated by the evaluation team. The other 11 scales were the direct responses of the consultant and the consultee (averaged, in the case of multiple consultees in a given consultation). These results, along with clinicians' and service chiefs' ratings of consultation in their own program were the basis of our site-by-site analyses in Volume III of this report.



3. Findings, Conclusions, and Recommendations

A total of 78 consultation activities conducted by 17 children's, crisis, and contract programs were selected for evaluation. We were able to obtain complete data on 45 of those activities.*

Thus, we were able to investigate the effectiveness of only about 58% of those activities initially selected for study. We analyzed all 78 consultations, however, to determine consumers, level of focus, and the extent to which community services in a program are invested in regular consultation

a) Who are the consumers of consultation?

WE CONCLUDE that the major consumers of mental health consultation provided by Alameda County Mental Health Services are other Alameda County agencies. Furthermore, the same consultation activity may be present in several different programs with no evidence of coordination between higher administrative levels of mental health and the consumer agency (for example, several Children's Programs independently provide consultation to welfare workers). Finally, there is no reflection in the mental health services's budget of the amount of service given to other County agencies.

WE RECOMMEND that in order to maximize the efficiency and effectiveness of consultation to other County agencies, we recommend that the local mental health director enter negotiations with the administrative heads of each other County agency which consumes a significant proportion of mental health consultation services. Those negotiations should focus on the objectives of consultation and preplanned methods for evaluating achievement of those objectives. Consumer agencies should be charged for extensive consultation, particularly training programs.

* For three of the other activities, the consultant had left the program or was on leave at the final stage of our study. In 10 instances, the consultee(s) were not available because of leaves or illnesses, or because the consultation had been terminated. For the remaining 20 activities, we were unable to obtain complete information from the consultants even though a full month had been allowed for the final stage of our study and despite follow-up memoranda from our office and from the regional mental health directors.

SUPPORT:

Responses to our initial questionnaire revealed a wide variety of consumers of consultation services. Table 8 presents a categorization of those consumers and a division between County agencies and others.

Other Alameda County agencies consume 37% of mental health services' regular and on-going consultation time, and about 50% of the consultees in those activities are other County employees.

WE CONCLUDE that County agencies which potentially serve the same clients need to have knowledge of each other's resources and perspectives. Orientation of new workers in County agencies does not include sufficient orientation to other agencies. In many instances, consultation appeared to be an attempt on the part of other agencies to obtain information about mental health services.

WE RECOMMEND that a resources and procedures manual for Mental Health Services should be prepared for distribution to other human services agencies in Alameda County. Mental Health administration should request equivalent manuals from other agencies whose services are often needed by mental health clients.

(The Support and Discussion for the above conclusions and recommendations appear on page 39.)

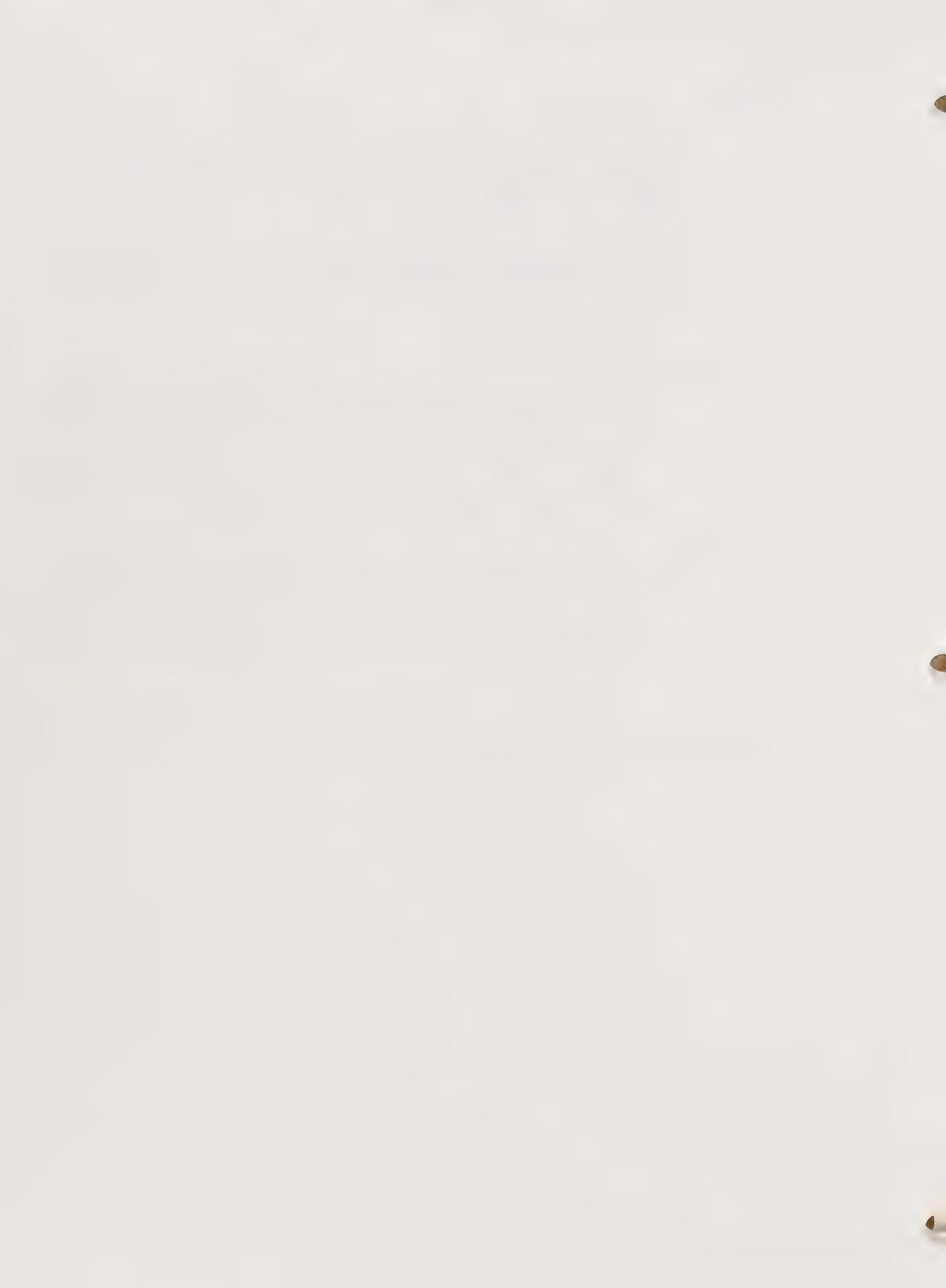


TABLE 8

Consumers of Mental Health Consultation

<u>County Agencies</u>	<u>People Per Month</u>	<u>Hours Per Month</u>
1. Welfare Department	62	16
2. Children's Protective Services, Foster Placement	61	23
3. Public Health Department	14	14
4. Probation Department	91	75
5. Other Mental Health Services	58	29
6. Other Health Care Services (Including Drug Programs)	44	19
TOTAL	316	176
PERCENT OF GRAND TOTAL	49.8%	37.0%
 <u>Non-County Agencies</u>		
1. Schools (Including Teachers, Administrators, Counselors)	138	136
2. Child-Care Centers (Pre-Schools, Headstart, etc.)	91	90
3. Family-Oriented Agencies (i.e., Parental Stress, Family Service)	34	33
4. Others (i.e., Red Cross, Ministers' Association, etc.)	55	40
TOTAL	318	299
PERCENT OF GRAND TOTAL	50.2%	62.9%



SUPPORT AND DISCUSSION

In the Linkages Section (IX) of this volume, we identified several patterns of connection between mental health services and other agencies who serve the same clients. Some of those same linkages were also apparent in our study of consultation services (for example, those with the Welfare and Probation Departments). It is clear that probation officers and welfare workers need to be informed about mental health services and procedures and vice versa. Mutual ignorance of the resources available among the various service agencies and conflicting policies of two or more agencies serving the same clients only result in reduced and inefficient service to the client. New clinicians in mental health are given no systematic orientation to other service agencies in spite of the fact that many mental health clients may need public assistance funds, vocational training, physical health care, or may be on probation. It is doubtful that new welfare workers or probation officers are given any better orientation to mental health services despite the fact that many of their clients may be in need of such services. What occurs instead is a piece-meal, fragmented pattern of consultation, attempting to accomplish in this fashion what could be accomplished more efficiently and effectively through administrative planning. Only through coordination and cooperation can mental health and the other County service agencies have their optimal impact.

WE CONCLUDE that second only to County service agencies, schools are the largest consumers of mental health consultation.

WE RECOMMEND that the chiefs of childrens' programs, with the assistance of a coordinator of children's programs, explore the needs of teachers and counselors with the principals and



administrators of schools in the community served. The goal of this exploration should be the development of training curricula, with measurable objectives, for school personnel.

SUPPORT AND DISCUSSION

Twenty-nine per cent of regular and on-going mental health consultation time is given to schools, and 22 percent of mental health's consultees are school personnel. It is obvious that in any program of prevention or early detection of mental illness, schools will be a primary focus. It is also clear that teachers must handle many children who present difficult behavior problems. Yet, mental health's impact is limited to some schools and not others, some teachers (who display the initiative to attend consultations) and not others. In consultation which is client or consultee-centered, only those kinds of problems which the consultees choose to bring up are discussed. Other problems, which school personnel might be reluctant to bring up for a variety of reasons, are neglected. We feel that mental health services could, and should, develop a training program for teachers and counselors which would address the crucial issues from mental health's point-of-view as well as those issues the school personnel initiate. Through a developed training program, school personnel can also be informed in a thorough and systematic fashion of mental health resources rather than relying on those personnel to seek out the information on their own initiative. We feel that every child deserves attention to his or her emotional well-being, not just those whose teachers have been sufficiently motivated to seek out mental health information.



- b. To what extent does regular and continuing consultation constitute a program's total community services activity?

WE CONCLUDE that our study revealed wide diversity in the proportion of community services given to regular and continuing consultation.

WE RECOMMEND that program chiefs and service modality coordinators insure that more than half of community services activity be developed into regular and continuing consultations (except when other objectives have higher priority).

SUPPORT AND DISCUSSION

Table 9 presents the hours each of the sixteen programs devoted to community service (excluding "Information and Education Visits") from the November, 1975 biostatistics and the hours devoted to regular and continuing consultation as reported as part of our study the same month.

With the exception of the Probation Guidance Clinic, Children's services reported a consistently high proportion of community services time given to regular, continuing consultation: 65 to 85 percent. The Probation Guidance Clinic devotes a large amount of time to handling crisis situations in Juvenile Hall and to consulting with probation officers wishing to make referrals. These are clearly explicit objectives for the Guidance Clinic, and its distribution of consultation time appears to reflect those objectives.

Adult Crisis programs, including both County-operated and contracted programs, report a small amount of time given to community services, compared with children's services, and a much lower range of percentage of that time given to regular consultation: from a low of 2 percent to a

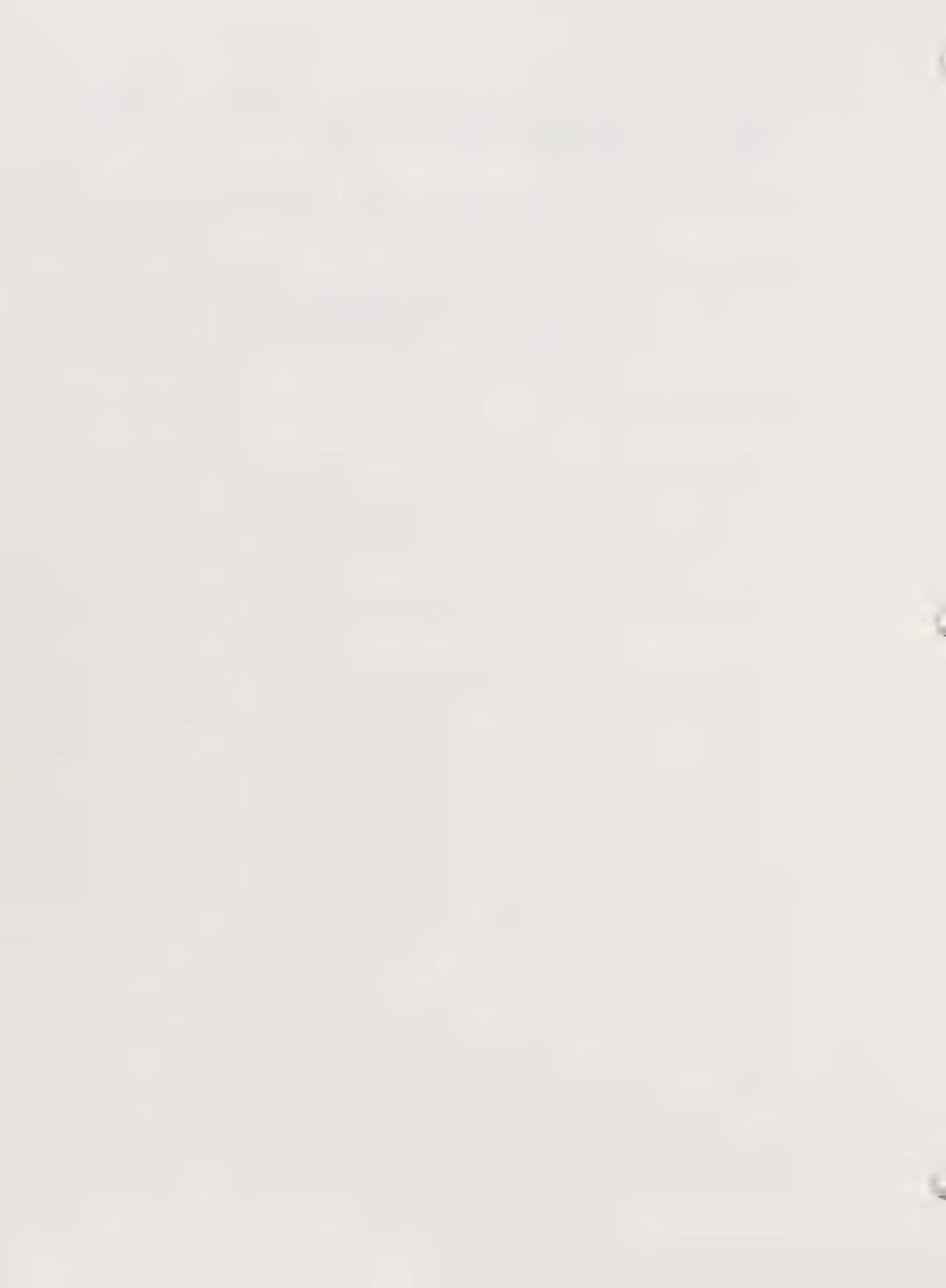
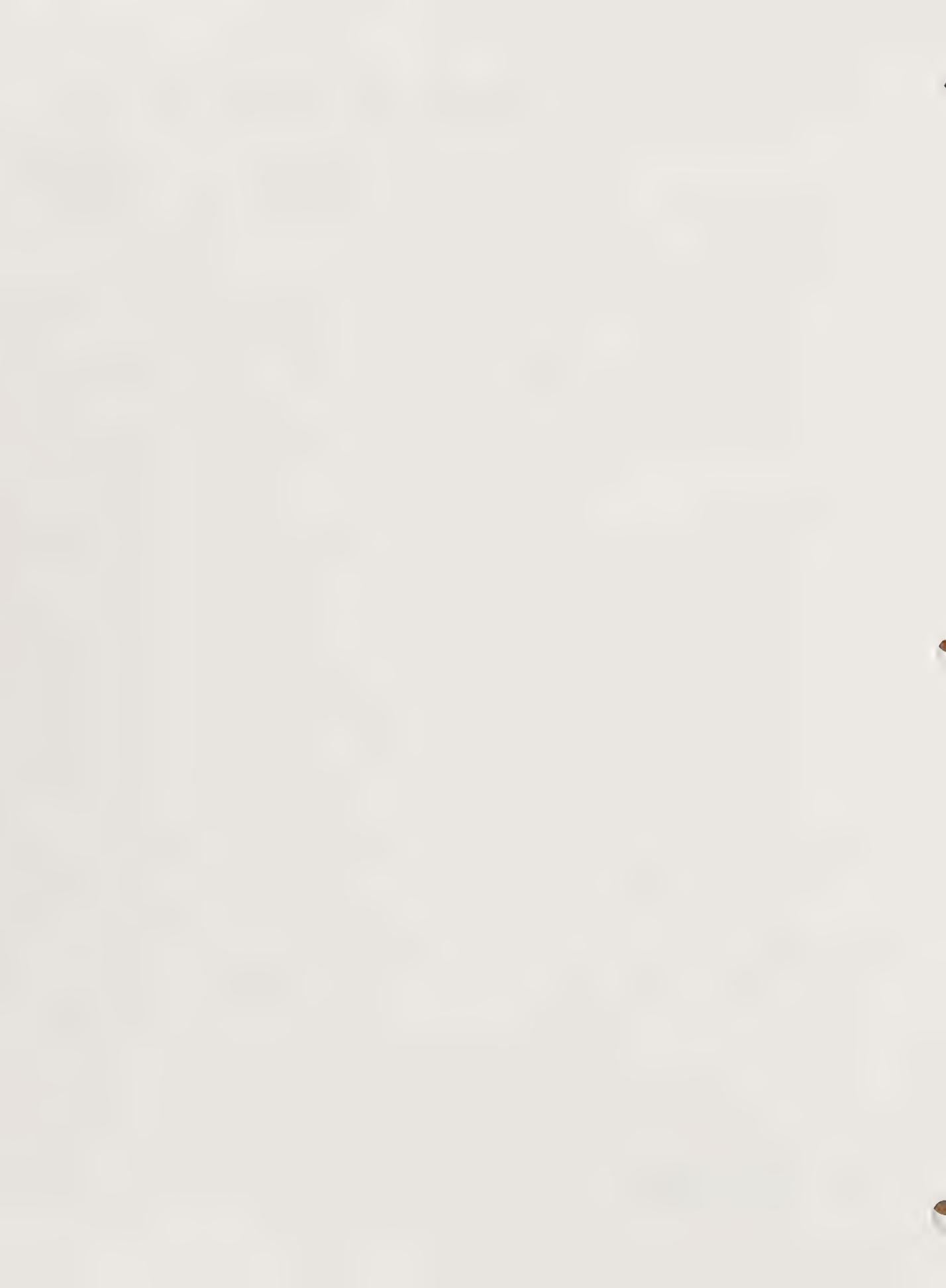


TABLE 9

Community Services Hours and Hours Given to Continuing Consultation in Each Program Studied

	Community Service Hours*	Continuing Consultation Hours
A. County Services		
<u>North Region</u>		
1. Central Child Development Service	115	75 (65%)
2. Central Crisis	8	9
3. Alameda Mental Health Clinic (Children's and Crisis)	44	46
4. East Oakland Crisis Service	19	45
<u>South Region</u>		
5. Eden Children's Service	108	92 (85%)
6. Eden Crisis Service	4	5
7. Tri-City Children's Service	65	46 (71%)
8. Tri-City Crisis Service	27	10 (37%)
9. Valley Children's Service	33	26 (79%)
10. Valley Crisis Service	32	8 (25%)
<u>Centralized</u>		
11. Probation Guidance Clinic	500	67 (13%)
B. Contractors		
12. Berkeley Crisis Service	(not reported)	11
13. El Centro de Salud Mental	201	54 (27%)
14. East Oakland Health Alliance	56	5 (9%)
15. Ann Martin Children's Center	36	24 (67%)
16. Asian-American Community Mental Health	137	3 (2%)
	1,385	526 (38%)

* As reported in the November, 1975 biostatistics, excluding "information and Education Visits" time.



high of 37 percent. Furthermore, four of the Crisis services, all County-operated, reported more time in regular consultations in our study than was reported in the biostatistics. Either those consultations reported in our study were not met during the month of November, or crisis services are consistently negligent⁹ in reporting consultation time in their biostatistics.

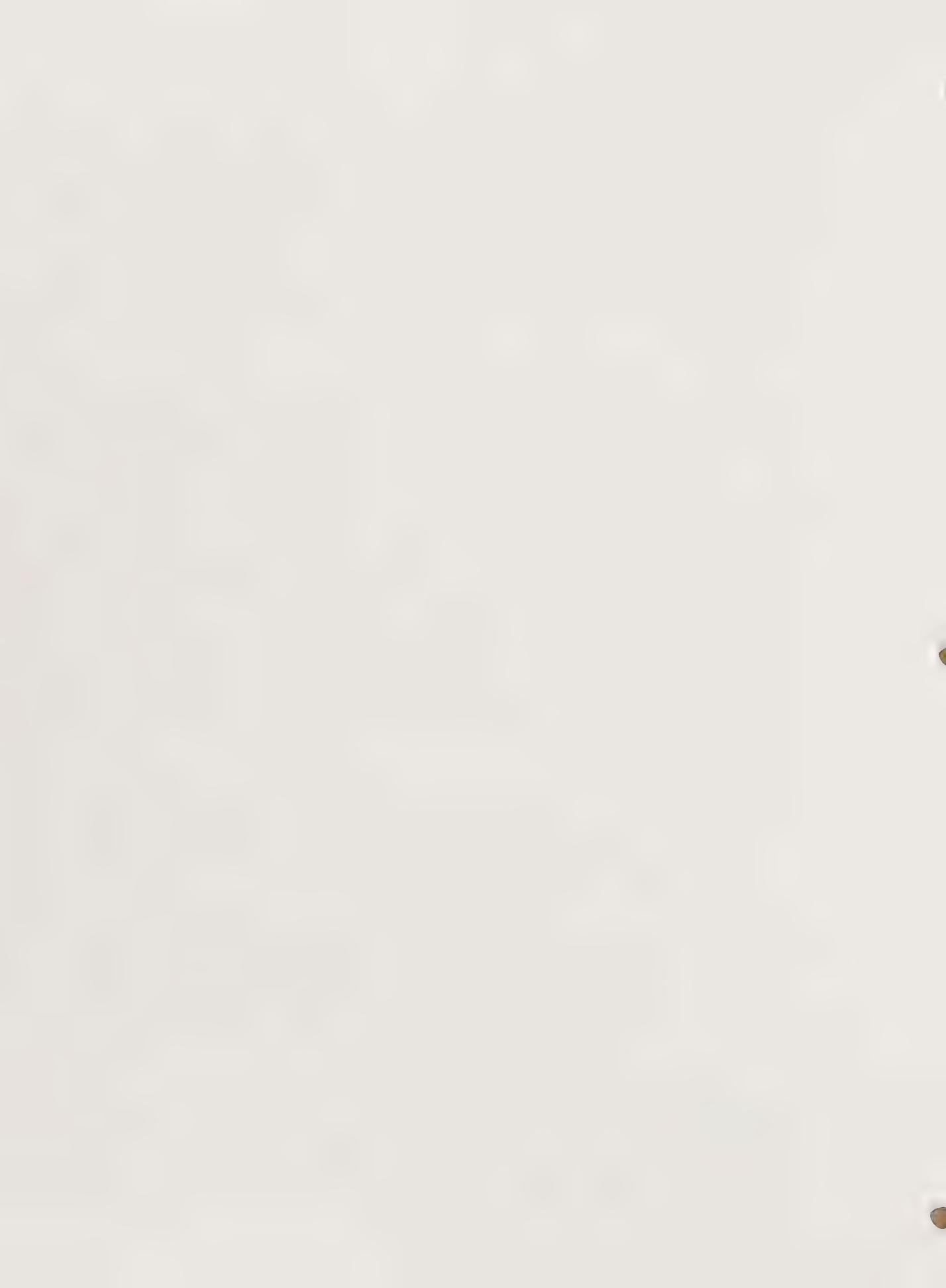
Our recommendation contains an assumption which should be made explicit. In a time when funds for mental health services are shrinking, it becomes more important to insure that activities are effective. Effectiveness can be determined only if it is possible to measure the achievement of objectives, and objectives can be specified only through an initial process of negotiation and commitment. Furthermore, a consultation activity has a much greater chance for effectiveness if both parties agree beforehand to a set of objectives and means for measuring progress toward meeting those objectives.

WE CONCLUDE that our study revealed that, compared with children's services, Crisis services devote little time to consultation and lower percentages of that time to regular, continuing consultation.

WE RECOMMEND that Regional Mental Health Officers confer with a coordinator of Crisis services and the chiefs of crisis services in their respective regions to determine the needs for consultation that might be most appropriately met by Crisis services and to establish the priorities of those needs.

SUPPORT AND DISCUSSION

A community mental health service must address the needs for prevention and early detection of mental illness in the whole community, not just



among its children. There are many mental health issues which come to the attention of law enforcement agencies, ministers, health and welfare departments, and so on, which would be inappropriately addressed by children's services. Problems of divorce, suicide, alcoholism, and substance abuse are just a few of the mental health issues to be found in the adult community, and adult mental health services, not children's, should respond to those issues. The absence of linkages between mental health and law enforcement agencies is examined in Section IV (Linkages) of this report.

c. At what level is mental consultation focused?

WE CONCLUDE Most goals cited by both the consultants and the consultees were consultee-centered, and relatively few program-centered goals were cited.

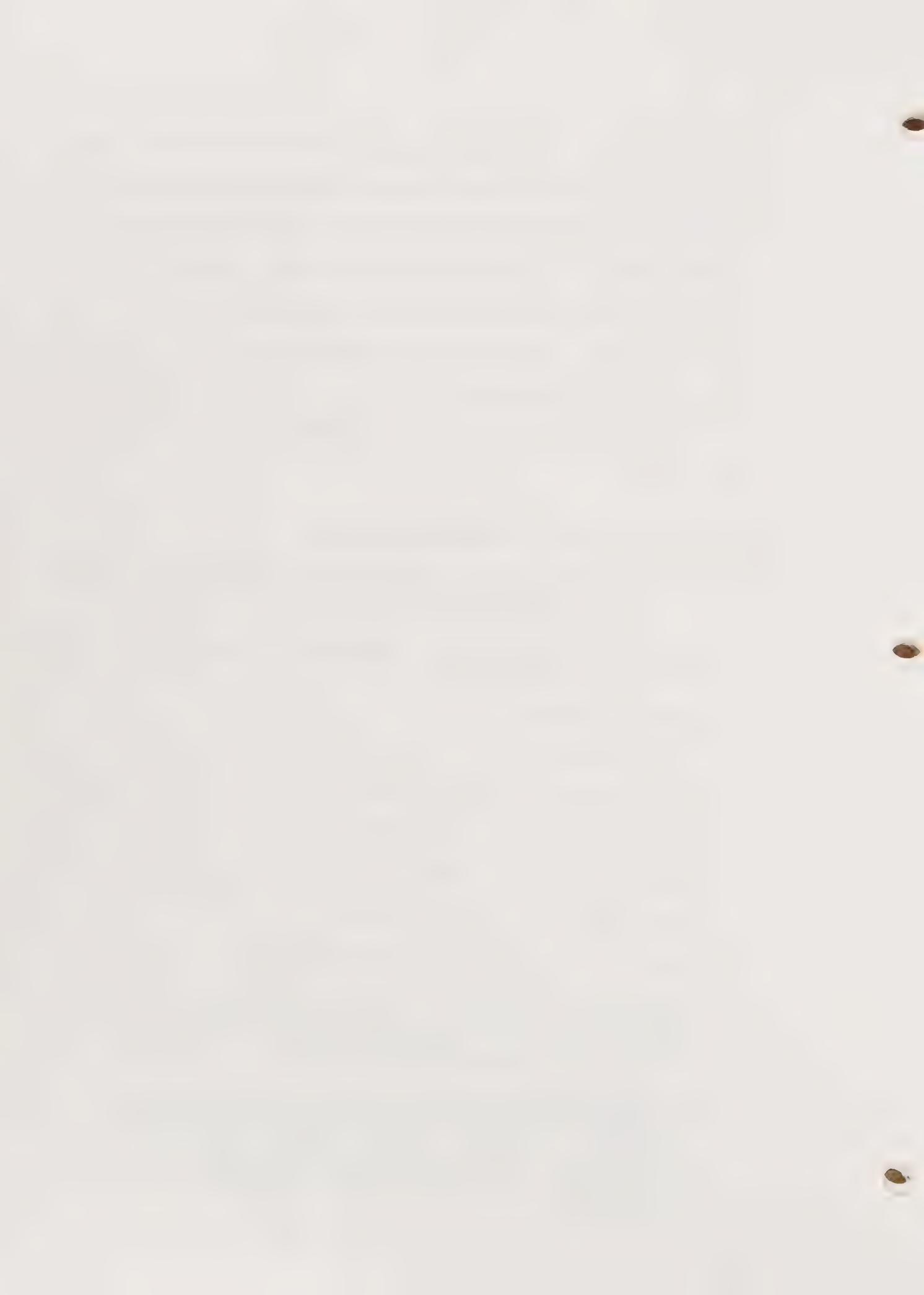
WE RECOMMEND that a greater share of consultation services be directed at the program level.

SUPPORT AND DISCUSSION

In the Introduction to this section of our report, we delineated program-centered, consultee-centered, and client-centered consultation. Our inquiry included asking both the consultants and the consultees to define the goals of the consultation. We then categorized each goal as program, consultee, or client-centered.

Some examples of goals cited by the respondents were :

1. Program-centered goals: "to clarify methods of service delivery....to develop a more productive working relationship....to set up a therapeutic program....liaison....lack of follow-through on referrals...."
2. Consultee-centered goals: "greater sensitivity and awareness of mental health problems on the part of the workers....increase skills....relieve stress and frustration....improve cooperation among staff,...greater ability to cope with behavior and mental health problems...."

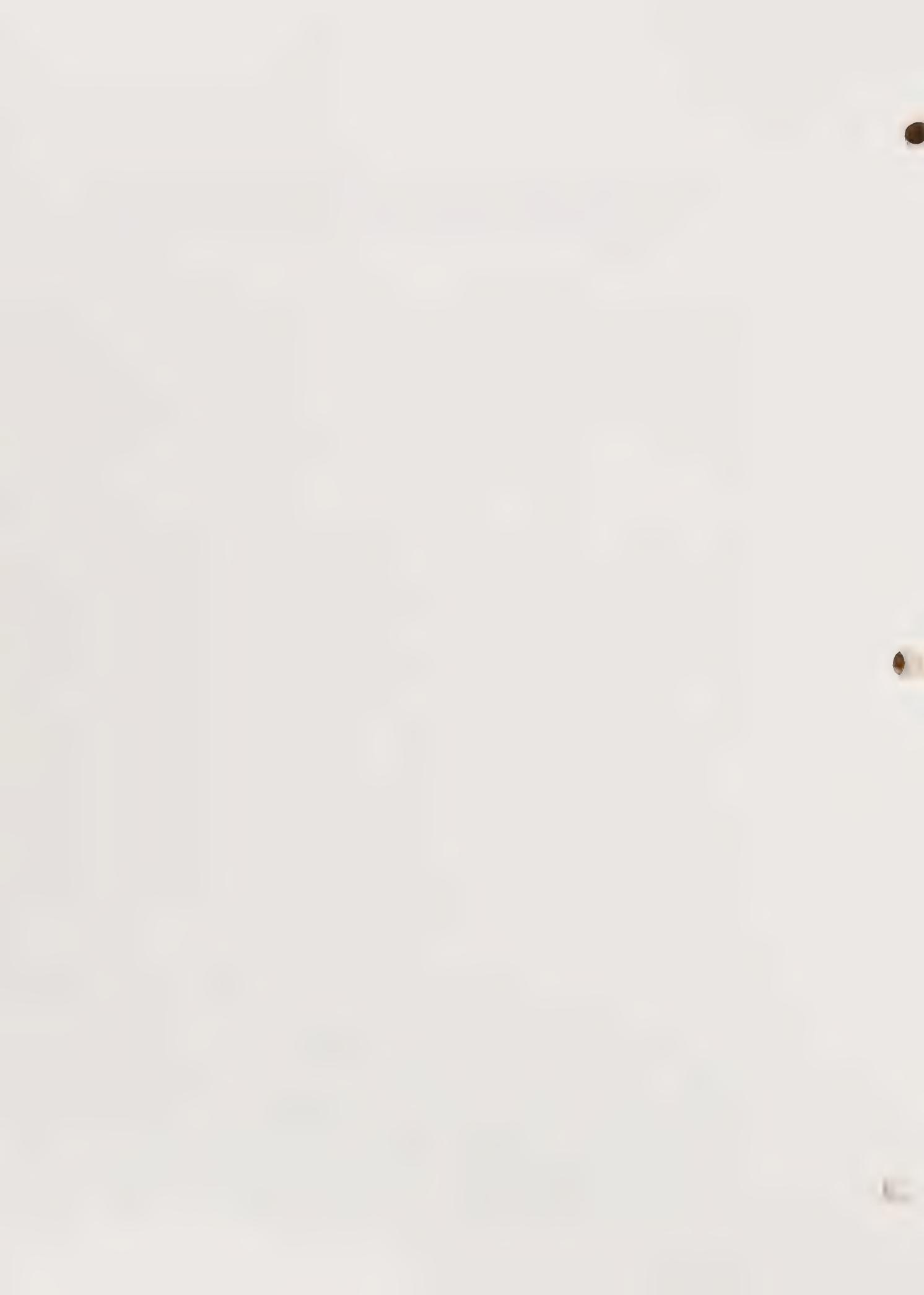


3. Client-centered goals: "case-finding...,making appropriate referrals....providing mental health input into decisions about juvenile offenders...,aid in individual case management...."

The consultants responsible for the activities we studied cited 31 program-centered goals (24%), 60 consultee-centered goals (46.5%), and 38 client-centered goals (29.4%). The consultees goals were remarkably similar in break-down: 47 program-centered goals (18.2%), 128 consultee-centered goals (49.6%), and 83 client-centered goals (32%).

As the focus of consultation moves from the individual client to the consultee and finally, the program, the breadth of potential impact of the consultation increases. Since program-centered consultation potentially influences all the clients of the agency requesting consultation, we feel that programs offering consultation should strive to have influence at the programmatic level whenever possible. Programmatic decisions are usually in the hands of administrators rather than line staff, and it usually requires some "delicacy" in getting administrators to recognize the value of consultation for themselves and not solely for line staff. This is not easy task, admittedly, but it should be a goal in the mind of any clinician providing mental health consultation.

Among those consultations focused at the consultee level, we noted very few structured training programs. As we discussed earlier, a structured training program has some advantages over consultation which is structured exclusively around issues raised by the consultees. Of course, negotiation for a training program usually involves administrative commitment of the staff's time for a specified period, plans for evaluation, and so on, but



we feel that the extra energy required for those negotiations is well worth the effort.

In the final analysis, the impact of consultation will always be influenced by the degree of administrative support for the activity and the extent to which goals have been explicitly shared and defined. For that reason, the consulting clinician is always well-advised to go through that process with administration before embarking on an activity. Several of the consultations we initially indentified did not survive our three-month period of evaluation primarily because that process did not happen. Mental health services cannot afford the luxury of too many aborted efforts,

d. How effective is mental health consultation?

WE CONCLUDE that consultation with other county agencies tends to be less effective, as measured by our scale of overall effectiveness, than consultation with non-county agencies.

WE RECOMMEND that consultation activities rated by our study as relatively less effective be closely examined by the consulting clinician, the program chief, and the consumer, especially in the case of consultation with other county agencies.

SUPPORT AND DISCUSSION

In Table 10, the 45 consultations for this we obtained complete data, are presented in order of effectiveness on our overall scale (see "Stage Four, Methodology). The distribution of scores was divided into quartiles, and those activities rated in the bottom 25 percent (12 consultations) of the distribution were compared with those in the top 25 percent (ten consultations). The top ten consultations included only one in which the consumer was another county agency. Of the 12 consultations rated as least effective, eight were with county agencies (two with Welfare, one with another



TABLE 10

Overall Effectiveness of Consultation Activities

<u>Consultant</u>	<u>Consumer</u>	<u>Ratings*</u>
1. Valley Crisis Service	Cura Detoxification Program	62.7
2. Asian-American Mental Health	Vocational Rehabilitation	61.0
3. Eden Children's Service	Children's Protective Services	60.0
4. Asian-American Mental Health	Herrick Hospital	60.0
5. El Centro de Salud Mental	Academia Emiliano Zapata	59.3
6. Alameda Children's Service	Alameda Schools Pupil Personnel	59.0
7. Tri-City Crisis Service	Second Chance	58.6
8. El Centro de Salud Mental	Oakland Schools Community Relations	58.5
9. Central CDS	Oakland Project Headstart (98th Avenue)	58.1
10. Tri-City Children's Service	Fremont R.O.P. Program	58.1
11. Central Crisis Service	Senior Action Program	57.1
12. Valley Children's Service	Horizons	56.5
13. Tri-City Crisis Service	Community Drug Council	56.2
14. Alameda Crisis Service	Family Service, Alameda	56.2
15. Ann Martin's Children's Center	Circle Pre-School & First Chance Project	55.7
16. Alameda Children's Service	Alameda High School Counselors	55.3
17. Central CDS	West Oakland Health Center	55.2
18. Central CDS	Oakland Schools Special Education Admissions Committee	55.0
19. Alameda Children's Service	Mastick School	55.0
20. Central CDS	Child Care Centers	54.8
21. Eden Crisis Service	Hayward Police Department	54.6
22. Eden Children's Service	Family Crisis Unit (Probation)	54.4
23. Eden Children's Service	Companions of Hayward	54.0
24. El Centro de Salud Mental	Centro Legal de la Raza	54.0

Table 10 (Cont'd)

<u>Consultant</u>	<u>Consumer</u>	<u>Ratings*</u>
25. Tri-City Children's Service	Agency for Infant Development	53.7
26. Central Crisis Service	International Inst. of East Bay	53.6
27. Valley Children's Service	Twin Valley Pre-School	53.3
28. Alameda Children's Service	Parental Stress	53.3
29. Eden's Children's Service	Norbridge Continuation School	53.0
30. Berkeley Crisis Service	Victoria Inn	52.5
31. Alameda Crisis Service	Alameda Adult School	51.6
32. Eden Children's Service	Fairmont Psych. Emergency	50.7
33. Eden Children's Service	Kimball High School	50.7
34. Central CDS	Children's Protective Service	50.4
35. El Centro de Salud Mental	La Escuelita	50.3
36. Central CDS	Oakland Project Headstart (Concordia)	49.8
37. Probation Guidance Clinic	Senior Boys Camp (Probation)	49.8
38. Central CDS	Child Welfare Unit	49.1
39. Tri-City Children's Service	Welfare Department	48.3
40. Eden Children's Service	Probation Guidance Clinic	48.2
41. Probation Guidance Clinic	Chabot Ranch	47.1
42. El Centro de Salud Mental	Educacion par Adelantar	47.0
43. Central CDS	County Foster Home Unit	46.8
44. Central CDS	Welfare Department	43.8
45. Alameda Crisis Service	American Red Cross	42.7

* On 13 five-point scales, yielding a composite score with a range from 13 to 65.



mental health service, two with Probation, and three with Children's Welfare, Protective Services, or Foster Placement). This difference between the two groups of activities seems too pronounced to be accidental. We would speculate that when a non-county agency seeks consultation, the effort and thought required are conducive to productive activity. In contrast, we wonder if a number of intra-county consultations are somewhat "habitual", both parties having lost sight of what the initial purposes of the consultation were and whether they still apply. These are precisely the efforts that mental health can no longer afford.

We were struck by the number of consultees who took the extra time to address comments to us via the evaluation forms. Many consumers of consultation seemed so grateful to be getting any assistance at all that they were hesitant to be critical for fear of losing that service. Their response only serves to highlight our conclusion that mental health has a great deal of value to offer the community through consultation and therefore, should not waste that activity.

WE CONCLUDE that clinicians in Alameda County Mental Health Services may lack the necessary expertise to provide highly effective consultation.

WE RECOMMEND that training in consultation be provided clinicians who wish to develop particular skill in the activity.

SUPPORT AND DISCUSSION

In six of the sixteen program we studied, over 50 percent of the clinicians rated consultation services in their program as only fair or poor.

Consultation is a relatively new activity for the traditionally trained

clinician, an activity which has gained prominence in the community mental health center movement. Just as with psychotherapy, there are definitely skills involved in consultation, and many clinicians may attempt to provide consultation without benefit of training in those skills.

The Health Training Resources Center of the State Department of Public Health has developed considerable knowledge and training capacity in the area of consultation, and we suggest that Alameda County Mental Health Services take full advantage of their resources.



APPENDIX:

IMPACT

CLIENT STUDY INSTRUCTIONS
Office of Program Evaluation
November, 1975

We are attempting to study levels of functioning of clients of mental health services in Alameda County, and some of the factors which make treatment more or less effective. In about three months, we will attempt to determine if a sample of those clients has improved, stayed the same, or gotten worse in functioning and some of the reasons why. We have limited time and manpower, so we desperately need your assistance in this awesome task. We want to carry out this study sensitively and intelligently so that the results will be of value to us all.

We have had three major considerations in mind. First, that the measure used be meaningful and of sound quality. The Spitzer Global Assessment Scale of functional impairment meets those criteria. Second, we feel strongly about preserving client confidentiality, and we have taken steps to ensure that concern. Third, we recognize that clinicians are very busy, and we are asking for no more of your time than is absolutely necessary for our study to be meaningful.

Please assist us by doing the following right away:

- (1) Make a list of the names of all clients for whom you have primary responsibility in your program. Include all clients with open charts, regardless of how often you see the client or how recently.
- (2) Assign a two-digit code number to each client, so what you end up with is something like:

Smith	-	01
Jones	-	02
Brown	-	26
Williams	-	27

and so on, in any order, until your list is complete.

- (3) Use this code number in completing the two-page "Client Study" and the one-page Global Assessment Scale for each of your clients.
- (4) FOR GOD'S SAKE, THIS IS IMPORTANT: Take whatever steps are necessary to make sure you don't lose the list of your clients and their code numbers. Make a copy or copies and hide them in several places. Create a special manila file folder for it. Take a copy home and put it in the refrigerator. Maybe give a copy to your head clerk. Whatever is necessary. At later points in time, we will be asking for additional information, about a sample of clients, for example about your client #14. If you have lost your list so you don't know who I mean by "your client #14," the study will fall apart and your friendly neighborhood researcher may be seen in a swan-dive off the Golden Gate Bridge.
- (5) In making the ratings, feel free to consult any and all sources of information to enhance the validity of your rating, including consultation with other staff who also have contact with the client, quick phone calls, whatever.
- (6) If the client is a child or teenager, substitute "school" for any references to "work" on the Global Assessment Scale, and keep in mind age-appropriate, developmental expectations.
- (7) Give your completed forms to one clerk in your clinic within three days of this training session. A member of our team will be around to collect them.
- (8) Please give me the opportunity to handle any of your questions, concerns, or complaints. I can be reached at 874-5804 (tie line: 882-5804). I promise to be nice, patient, understanding, consoling, and not to cry even once.

Bless your hearts for your help,

Jim Sorrells, OPE

gk

CLIENT CHARACTERISTICS

- (13) I expect this client to be receiving services in this program for about _____ more months.
- (14) Client's age, to nearest year: _____ (15) Client's gender: Male/Female (circle one)
- (16) Client's ethnicity: _____ a. Caucasian _____ e. American Indian

b. Black _____ f. Polynesian (Hawaiian,

c. Spanish surname _____ Filipino, Samoan, etc.)

d. Asian _____ g. other: _____
- (17) Client's (or if a minor, the parents') approximate living standard:
- _____
a. probably upper-class (professional)

b. probably middle-class (white collar)

c. probably labor-class (blue collar)

d. on some form of public assistance (SSI, AFDC, GA, etc.)
- (18) Client lives (as of this date):
- _____
a. alone (whether in a house, apartment, or hotel room)

b. with immediate family (parents or siblings)

c. with extended family (aunt or uncle, cousins, grandparents)

d. with non-related "roommate(s)"

e. with a "spouse" (whether married or not)

f. in a foster or group home, board-and-care home, or half-way house

g. don't know for sure
- (19) A. To the best of my knowledge, this client has never been hospitalized for psychiatric reasons (answer question #20 and skip #21 and #22).

B. To the best of my knowledge, this client has been hospitalized only one time for psychiatric reasons (skip #20 and answer #21 and #22).

C. To the best of my knowledge, this client has been hospitalized times for psychiatric reasons (skip #20 and answer #21 and 22).
- (20) If the client has never been hospitalized, is your treatment plan clearly an attempt to prevent a first hospitalization?

Yes, clearly.

No, hospitalization is not seen as a great risk.
- (21) If the client has been hospitalized only one time,

a. it was probably a "first break" experience.

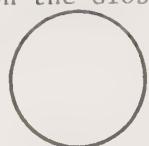
b. there were probably earlier "breaks" even though hospitalization did not occur.

c. not sure.
- (22) If the client has ever been hospitalized, how many months have passed since discharge from the most recent hospitalization?

months



CLIENT STUDY
OFFICE OF PROGRAM EVALUATION
NOVEMBER, 1975

- (1) Client's code number _____ (2) Client's rating on the Global Assessment Scale: 
- (3) Name of your clinic or service _____
- (4) Your name and job title _____
- (5) Today's date _____
- (6) The date that this client formally became a client in your program for this current treatment period (i.e., chart was opened): _____
- (7) The date that this client formally became part of your caseload for this current treatment period: _____
- (8) The total number of (a) out-patient visits and/or (b) program days (depending on the nature of your service) with any staff member of your service, this client has received during the current treatment period:
a. out-patient visits _____
b. program days _____
- (9) This client has received, from any member of your staff during this current treatment period:
(check all that apply)
- | | | |
|--|-------|--|
| a. medication | _____ | h. socialization program |
| b. individual therapy | _____ | i. recreation program |
| c. group therapy | _____ | j. assistance concerning vocational training or jobs |
| d. family therapy (collateral or conjoint) | _____ | k. assistance concerning housing |
| e. milieu therapy | _____ | l. assistance concerning finances |
| f. crisis contacts | _____ | m. other: _____ |
| g. diagnostic evaluation | _____ | |
- (10) This client is presently receiving the following kinds of treatment:
(check all that apply)
- | | | |
|--|-------|--|
| a. medication | _____ | h. socialization program |
| b. individual therapy | _____ | i. recreation program |
| c. group therapy | _____ | j. assistance concerning vocational training or jobs |
| d. family therapy (collateral or conjoint) | _____ | k. assistance concerning housing |
| e. milieu therapy | _____ | l. assistance concerning finances |
| f. crisis contacts | _____ | m. other: _____ |
| g. diagnostic evaluation | _____ | |
- (11) Counting all kinds of treatment and services, this client is presently receiving approximately _____ hours of treatment per month.
- (12) My involvement with this client is primarily in terms of (from the above list): _____



GLOBAL ASSESSMENT SCALE (GAS)

Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph.D.

Rate the client's LOWEST level of functioning in the last week or at last contact by selecting the lowest range which describes his or her functioning on the scale of mental health/illness below. For example, a client whose "behavior is considerably influenced by delusions (range 21-30)" should be given a rating in that range even though he has "major impairment in several areas (range 31-40)." Choose an exact number (e.g., 35, 58, 63) to indicate whether you rate the client at the low, middle, or high part of the range. Rate actual functioning independent of whether or not the client is receiving and may be helped by medication or some other form of treatment, and independent of treatment goals.

Your name and job title _____ Client's code number _____

Name of clinic or service _____ Rating:

Today's date _____

- 100 No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her warmth and integrity.
- 90 Transient symptoms may occur, but good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, "everyday" worries that only occasionally get out of hand.
- 80 Minimal symptoms may be present but no more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand.
- 70 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him or her "sick."
- 60 Moderate symptoms or generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
- 50 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking).
- 40 Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single serious suicide attempt.
- 30 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts grossly inappropriately).
- 20 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).
- 10 Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal hygiene.



Revision of the Global Assessment Scale
for optional use in rating
children under 12

100-91 Superior functioning in many areas, good functioning in all areas.

90 | Good functioning in all areas. Fundamentally secure in family, school, and with
| peers so that situational responses are transitory, non-symptomatic (i.e.,
81 | acknowledged and managed by child), and do not interfere with functioning.

80 | Slight interference with functioning in family, school, or with peers. Healthy
| responses to situational crises may produce symptoms, but symptoms are minimal,
71 | brief, and only slightly interfere with functioning.

70 | Some difficulty in functioning in family, school, or with peers due to normal
| responses to developmental crises (e.g., age-appropriate phobias, separation
61 | anxiety), but these symptoms do not seriously impair functioning. The symp-
| tomatic behavior would not be sufficiently intense to label the child as
disturbed.

60 | Moderate difficulty in functioning in family, school, or with peers due to mild
| symptoms (mild adjustment reactions, reactive disturbance, mild peer relation
51 | problems, mild psychosomatic problems, mild habit or conduct disturbances, bed-
| wetting, neurotic traits). Functioning may be constricted, but still appropriate.

50 | Clear interference in functioning in family, school, or with peers due to serious
| impairments in personality development (e.g., personality disorders (GAP),
41 | oppositional child, impulsive-ridden child, poorly socialized child). Most
| clinicians would agree that these symptoms represent disturbance.

40 | Major impairment in functioning in family, school, or with peers due to severe
| symptoms (e.g., psychoneurotic disorders, severe behavior disorders, withdrawal,
31 | aggression, hyperactivity, severe or persistent psychosomatic complaints, re-
| current destructive or self-destructive behavior, compulsiveness, obsessions,
| severe or frequent anxiety).

* 30 | Unable to function in some but not all areas in family, school, or with peers
| due to gross disruption in behavior or difficulties in object relations or in
21 | differentiation of reality and fantasy.

* 20 | Needs almost constant supervision due to severely destructive or self-destructive
| behavior or gross impairment in reality testing, communication, cognition,
11 | affect, object relations, or personal hygiene.

* 10 | Needs constant supervision (24-hour care) due to severely destructive or self-
| destructive behavior or gross impairment in reality testing, communication, cog-
1 | nition, affect, object relations, or personal hygiene.

* Autistic, symbiotic, psychotic, or borderline children may appear anywhere from
1 to 30 on this scale, depending on ability to function.



CLIENT STUDY FOLLOW-UP

Your cooperation has already enabled us to obtain data on more than 3,000 clients of Alameda County Mental Health Services. About 1,000 clients were rated on the Global Assessment Scale as having major psychiatric impairment. We randomly selected about 400 of those clients for re-assessment as the final stage of our study.

Your client _____ was selected as part of our sample of 400 clients. Please rate this client again using the attached Global Assessment Scale. Base your rating on your most recent impressions of the client, whether still in treatment with you or not. Complete the other questions and return this questionnaire to the OPE team member.

With much gratitude,

James Sorrells
Office of Program Evaluation

1) Clinician: _____

2) Site: _____

07-08/ 3) This client: (check only one, please)

- 1. is still in treatment with me or in this program;
- 2. has terminated treatment, with my agreement;
- 3. has terminated treatment, against my advice;
- 4. had to terminate because client had to move or other factors (job, etc.)
- 5. has stopped coming in, without explanation;
- 6. is now hospitalized at: _____;
- 7. was hospitalized since last December, but now back in treatment with us;
- 8. was hospitalized since last December, but now in treatment in another program in the community: _____;
- 9. was hospitalized since last December, has been discharged, but I don't know where the client is or whether he or she is receiving treatment;
- 10. has been transferred to another program: _____;
- 11. has died.

09-10/ 4) Your rating of this client on the GAS based on your most recent impressions:



11/ 5) This client is: _____

- 1. getting worse;
- 2. stable;
- 3. improving;
- 4. don't know.

12/ 6) How motivated has this client been since last December to improve his/her level of functioning?

- 1. not motivated at all;
- 2. very little motivation and/or with ambivalence;
- 3. somewhat motivated an/or with ambivalence;
- 4. very motivated (although some ambivalence may be present);
- 5. don't know

13/ 7) For this client, do (or did) you expect the services you and your program are providing to result in:

- 1. no significant improvement in functioning;
- 2. very little improvement in functioning;
- 3. some improvement in functioning, or improvement only in some respects;
- 4. considerable improvement in functioning, although not necessarily in all respects;
- 5. don't know.

14-15/ 8) Using the GAS again, what rating would indicate the highest realistic expectations for this client's functioning in the foreseeable future?



INTERVIEW FORMAT / EFFECTIVENESS STUDY

- 01-06/ 1) _____ Clinician: _____
Site: _____
- 07-08/ 2) This client is:

1. still in treatment here;
2. terminated, with agreement;
3. terminated, against advice;
4. had to terminate; reason: _____;
5. stopped coming in; attempt to locate? _____;
6. now hospitalized at: _____;
7. was hospitalized, now back in Rx here;
8. was hospitalized, now in Rx at: _____;
9. was hospitalized, now discharged, don't know where;
10. transferred to: _____;
11. died
12. other: _____;
- 09-10/ 3) Last December, you rated this _____ on the GAS. What about the client led you to that rating?
- 4) What have been your treatment goals for this client?
- 11-12/ Goal 1
- 13-14/ Goal 2
- 15-16/ Goal 3
- 17-18/ 5) (If not clear from Q.4) In what particular way(s) is the treatment you and your program are providing intended to improve this client's level of function?
- 19/ 6) Do you expect

1. no significant improvement in functioning?
2. very little improvement in functioning?
3. some improvement, or only in some respects?
4. considerable improvement, though not necessarily in all respects?
- 20-21/ 7) Why? (Limitations or resources; reasons, etc.)
- 22/ 8) How motivated is the client to improve functioning?
1. not at all;
2. very little, ambivalence;
3. somewhat, ambivalence;
4. very motivated (some ambivalence allowed);
5. DK



FOR NEVER HOSPITALIZED CLIENTS

23/

9) Do you feel that your present Rx can prevent an initial hospitalization?

1. DK 3. Probably not 5. Yes
 2. No 4. Hopefully, maybe 6. DNA (blank)

Comments:

FOR PREVIOUSLY HOSPITALIZED CLIENTS (blank - DNA - for never hospitalized clients)

24-25/

10) What might have prevented the most recent hospitalization?

01. DK
 02. Could not have been prevented;
 03. - 99:

26/

11) Did the most recent hospitalization have positive value for the client?

1. Yes
 2. No
 3. DK

27/

12) Did you receive any information or guidelines from the most recent hospitalization of relevance or useful to current treatment?

1. received no information
 2. received information but not useful or relevant
 3. received useful information
 4. DK

28-29/

13) (If hospitalized several times) Is there a pattern or set of recurrent factors which result in this client's readmissions to psychiatric hospitals?

01. DNA 04. Yes, but can't specify
 02. DK 05. - 99:
 03. No

30/

14) Do you feel that the current treatment you are providing can prevent additional hospitalizations in the foreseeable future?

1. DK
 2. No
 3. Probably not
 4. Hopefully yet
 5. Yes

Comments:



APPENDIX: CONSULTATION MATERIALS

DATE: November 4, 1975

TO: All Alameda County Crisis and Children's Services
and Directors of Select Contract Programs

FROM: James Sorrells, Ph.D., MPh.H., Office of Program
Evaluation *JS*

SUBJECT: EVALUATION OF CONSULTATION SERVICES

As you probably know, this office was given a mandate from the Board of Supervisors to evaluate the County mental health services and to report to the Board by March 16, 1976.

Our initial overview process established several major issues which we feel ought to be part of the focus of that evaluation. Our Ad Hoc Advisory Committee, including representatives from the Agency, Advisory Board, contractors, and district committees concurred in our judgment.

One of the issues raised was the impact, or effectiveness, of mental health services. We will attempt to measure impact in two ways. First, we will attempt to define and locate the most seriously impaired clients of our services and to illuminate the factors which influence the effectiveness of the treatment they receive.

Our second method of examining impact is the subject of this memorandum. Since the promotion of mental health in the community is a goal of the Mental Health Agency, and since consultation (indirect or community services) seems to be the major activity directed toward the promotion of mental health through prevention and early detection of mental illness, we have chosen to evaluate consultation (along with treatment to the seriously impaired client). A review of 1974-75 biostatistics indicate that consultation is a significant activity only in crisis and children's services and in certain contract programs. Thus, your inclusion in this part of our evaluation.

Let me try to define consultation as precisely as possible for purposes of this study. Consultation is any activity in which a member of your staff meets with a person or persons from another agency to discuss mental health or developmental issues. Typically, agencies which utilize mental health consultation include schools, nurseries, law enforcement or probation agencies, and welfare, although many other consultees might not fit those categories. A consultee might also be another mental health service, either private or part of the mental health agency. The consultee(s) might be line clerical or clinical staff, professionals or paraprofessionals, or administrators. The focus of the consultation might be the consultees themselves, or the program and its administration or clients. The clients of the consultee agency might or might not overlap with the clients of the consulting agency.



November 4, 1975

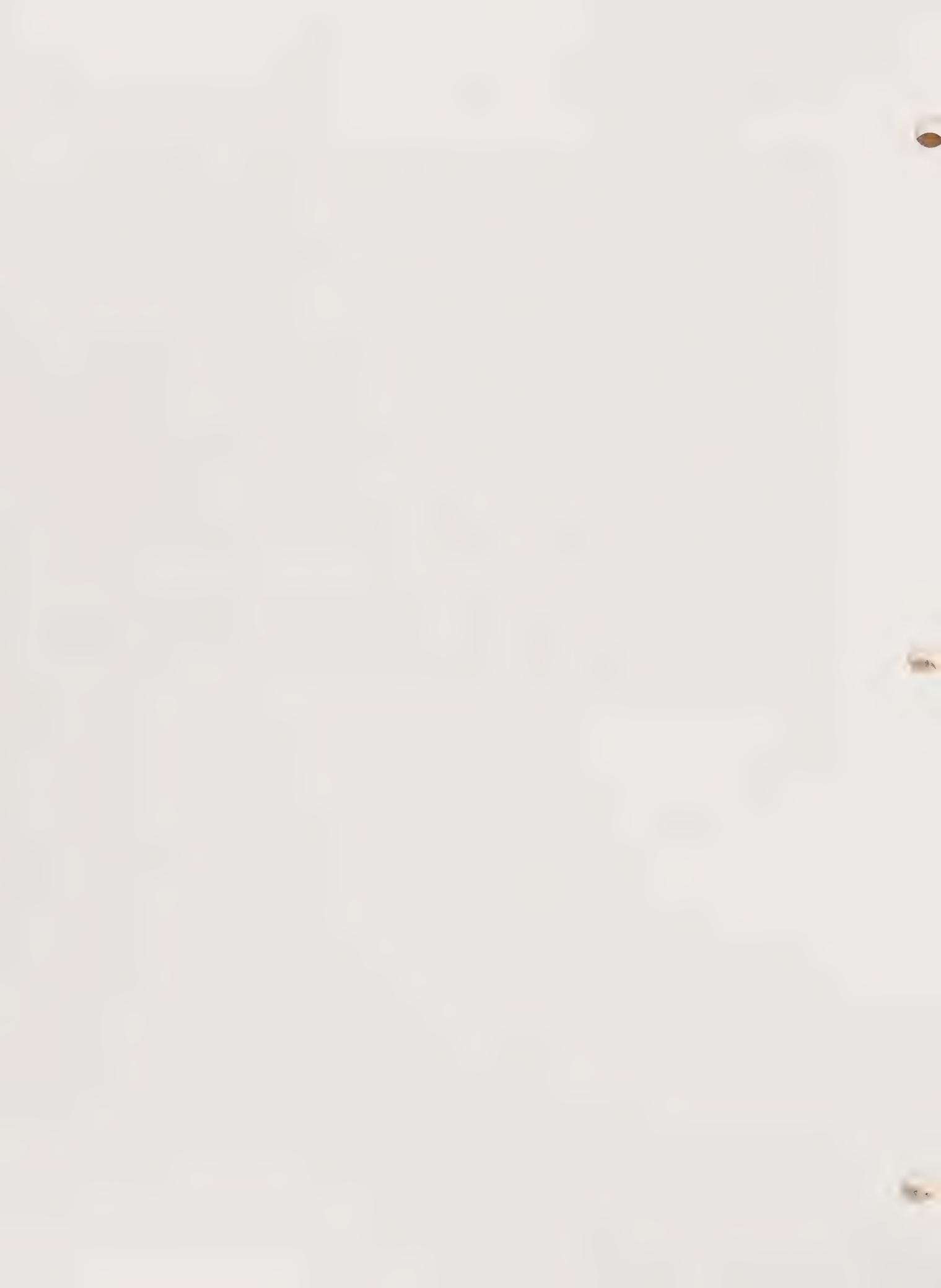
Excluded from this definition of consultation are collateral contacts with significant others in a client's life, such as family, employers, or teachers of a particular client. If a clinician meets with a teacher to implement treatment of a particular youngster whom the clinician is seeing in therapy, that activity is something other than consultation. But if the same clinician met with the same teacher to talk about how the teacher or the program deals with emotionally disturbed children, that would be defined as consultation.

For purposes of this study, I am only interested in regular, on-going consultation your service provides. By specifying "regular, on-going," I mean to exclude sporadic, one-shot services. Instead, I want to know about those consultations for which it would make sense to talk about a "contract (arrangement, agreement, etc.)," a staff person who has primary responsibility for the consultation, and some objectives for the consultation. I want to stress that, by excluding one-shot consultations and consultation-and-education visits with people seeking advice, we are not implying that those activities are not valuable functions of a mental health service. Quite the contrary, we want to document those activities of a service which are uniquely valuable yet may not show up in statistical records. For the purposes of this part of the evaluation, however, we have chosen on-going consultations as a relatively more meaningful and measurable function to study.

I am enclosing several copies of a form which will help me determine which consultations to study in greater depth. The form calls for you to describe some basic aspects of each consultation. Since time is of the essence, please assist me by getting this information back to me by November 12, 1975, and if you have questions, please call me at 874-5804.

JS:dh

Enclosures



(The name of your clinic, service, or center)

(Your name and title)

(Date)

1. Who is the consultee? Please be as specific as possible: e.g., "an average of six to 10 teachers at Middleville Elementary School," or "Sgt. Smith of the Pineville Police Department who is in charge of domestic quarrels," etc.
2. Who is the staff person in charge of or primarily responsible for the consultation, and what is the staff person's professional role (e.g., PHN, Social Worker, etc.).
3. When did the consultation formally begin (as opposed to preliminary planning or negotiation)?
4. Is this a "renewal of a consultation arrangement that was initiated in previous years?
5. How often does your staff member meet with the consultee(s), and for how long?



6. How much longer is it anticipated that the consultation will continue?

7. What would you say are the objectives or goals of this consultation, either from your service's point-of-view or the probable point-of-view of the consultee(s)?

8. Would there be any strong objections to our asking your staff member to define some objectives and to evaluate progress toward attaining them after three months?



Office of Program Evaluation
1221 Oak Street Room 458
Oakland, California 94612

December 29, 1975

Dear

Regarding your consultation with: _____

You responded to my questionnaire by stating that the goals or objectives of this consultation are: _____

I would like you now to specify any concrete or objective indicators you are using or might use to determine if the goals of the consultation are being achieved. For example, if an objective of a consultation to a group of teachers were to educate the teachers to recognize emotional disturbance in their pupils and to make referrals, a measure of success in meeting that objective might be the number of appropriate referrals made since the consultation began. Another example: if a goal of consultation were "to increase the effectiveness of workers," then an effectiveness rating by the workers' supervisors might be a measure of success of the consultation.

I am very well aware that consultation is one of the most difficult mental health activities to evaluate. Bearing that in mind, would you please try to suggest some indicators of success or non-success with respect to the goals and objectives reiterated above:

With respect to Goal 1: _____

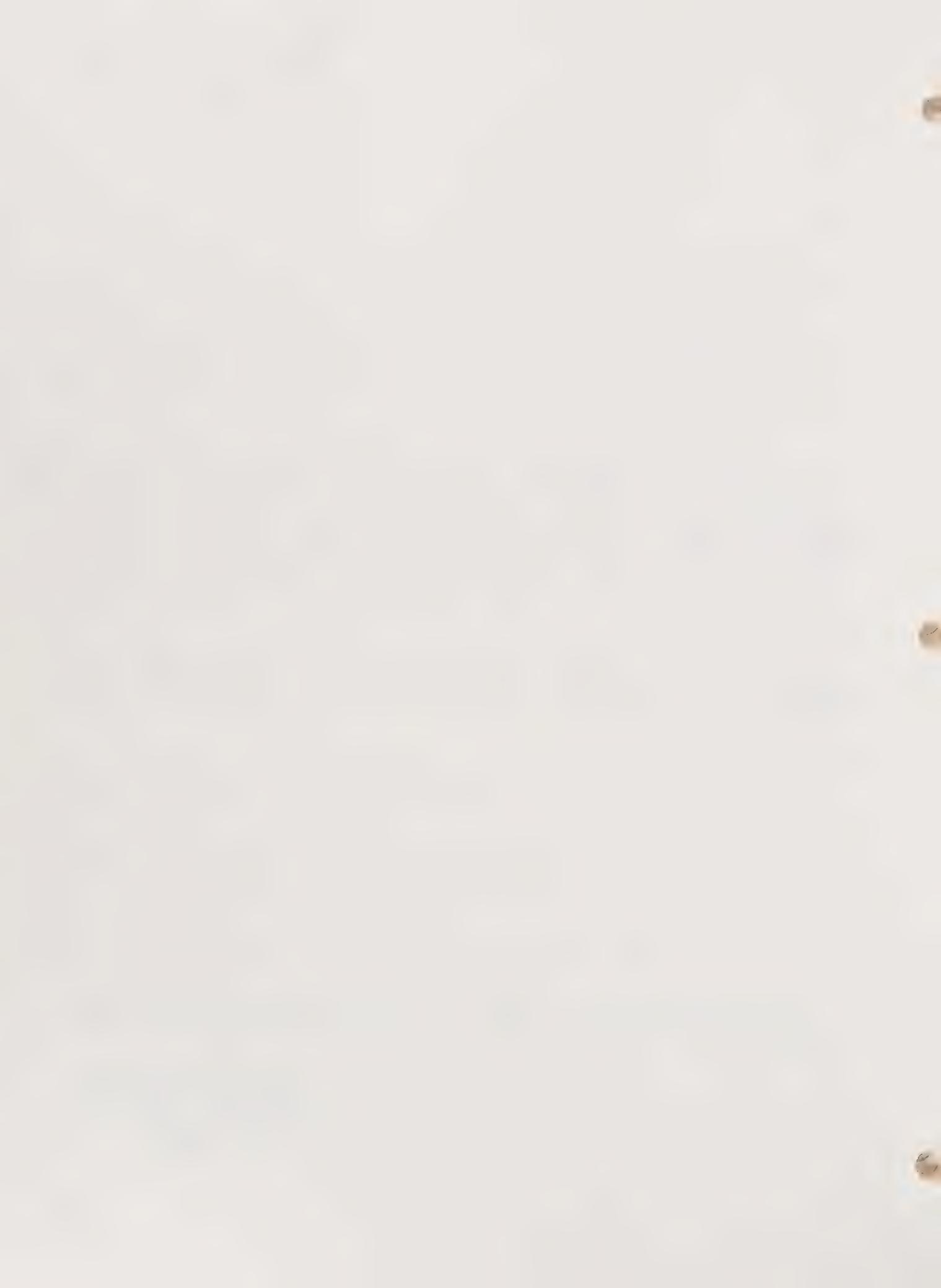
With respect to Goal 2: _____

With respect to Goal 3: _____

Please return this to me within two weeks using QIC CODE #20105. Your assistance will be valuable in making our evaluation as meaningful as possible.

Sincerely yours,

James Sorrells
James Sorrells, Ph.D.
OPE



Dear CONSULTANT : Re your consultation with: _____

This is the final stage of our study of consultation services. So that we can polish off this part without nagging phone calls and memos, please do the following:

I have enclosed copies of a rating form devised for your consultees (please xerox if you need more). The next time you meet with this consultation, please begin the session by asking your consultee(s) to complete the form. Use the time (surely no more than five minutes) to complete this form yourself. Urge your consultee(s) to be as honest in their responses as possible; none of this will have any value to you or us if the consultees are "nice guys" who say the "right thing". Please feel free to look over the forms, but return the whole bunch to me as soon as possible.

Thank you sincerely for your cooperation now as in the past.

Jim Sorrells

Please select the one response which best answers each question:

- (1) To what degree do you feel that the goals of this consultation are being met? (Please refer to your responses to my questionnaire of December 29, 1975, attached).

Goal 1: _____	USE	1 - Not being met at all
Goal 2: _____	THIS	2 - Barely being met
	RATING	3 - Being met reasonably well
Goal 3: _____	SCALE	4 - Being met quite well
		5 - Being met extremely well

- (2) How satisfied are you with the ways you have performed your role as consultant?

Very dissatisfied Somewhat dissatisfied Neutral Generally Satisfied Very Satisfied

- (3) How satisfied are you with the ways the consultation time has been used, for whatever reasons?

Very dissatisfied Somewhat dissatisfied Neutral Generally Satisfied Very Satisfied

- (4) In general, how satisfied are you with the outcomes or results of this consultation thus far?

Very dissatisfied Somewhat dissatisfied Neutral Generally Satisfied Very Satisfied

- (5) How valuable do you feel this consultation has been to your consultees in their work or their feelings about their work or themselves?

Very dissatisfied Somewhat dissatisfied Neutral Generally Satisfied Very Satisfied

- (6) How valuable has this consultation been to you, either in your professional development or your feelings about your work or yourself?

Not at all valuable Of little value Of questionable value Of some value Extremely valuable

PLEASE USE THE OTHER SIDE FOR COMMENTS



Dear Consultee:

The Office of Program Evaluation was directed by the Board of Supervisors to conduct an extensive study of mental health services in Alameda County. One part of our evaluation has focused on consultation services. We would appreciate your assistance in making our study meaningful. Your honest feedback will certainly increase the value of services that mental health provides to the community.

Thank you sincerely.

(The name of your program or agency)

(1) What would you say have been the goals or objectives of this consultation?

Goal 1: _____

Goal 2: _____

Goal 3: _____

(2) To what degree do you feel that the goals of this consultation are being met?

Goal 1: $\frac{2}{3}$ - Not being met at all

= rarely being met

3 = Below not reason

3 - Being not reasonably well
4 - Being not quite well

4 - Being met quite well

5 - Being met extremely well

Goal 3: _____ 5 - Being met extremely well

(3) How satisfied are you with the ways the consultant has performed his or her role?

Very dissatisfied Somewhat dissatisfied Neutral Generally Satisfied Very Satisfied

(4) How satisfied are you with the ways the consultation time has been used, for whatever reasons?

Very _____ Somewhat _____ Neutral _____ Generally _____ Very
dissatisfied dissatisfied satisfied satisfied

(5) In general, how satisfied are you with the outcomes or results of this consultation thus far?

Very _____ Somewhat _____ Neutral _____ Generally _____ Very
dissatisfied _____ dissatisfied _____ _____ Satisfied _____ Satisfied

(6) How valuable has this consultation been to your work or your feelings about the search on yourself?

Not at all Of little Of questionable Of some Extremely
valuable value value value valuable



COST
AND
PRODUCTIVITY



COST AND PRODUCTIVITY

Summary of Conclusions and Recommendations

In General -

WE CONCLUDE that most of Alameda County's County-operated and contracted mental health services exhibit low cost-efficiency and productivity; 59 percent of the 32 services studied have over 50 percent of total monthly staff time unallocated to either direct or indirect service and 29 percent of the 32 services possess above average unit costs.

WE CONCLUDE that the status of productivity within most mental health services is a very serious issue, especially when budgetary pressures are affecting the future of our County-operated and contracted services.

WE CONCLUDE that county-operated hospitals are expensive places in which to have community mental health services.

WE RECOMMEND that the Mental Health Director and Regional Directors begin to meet with the service chiefs of those services identified as having low productivity, to take immediate steps to improve the present situation. A re-assessment of present staffing patterns, workloads and needs should take place and be documented in a specific plan agreed upon by the Mental Health Administration and service chiefs. In turn, this should be linked directly to longer range improvements in management, training, objective - setting, morale, and location of services.

Cost

Specifically -

WE CONCLUDE that the present amount of HCSA overhead charged to Mental Health is overstated, i.e., the amount of overhead charged to Mental Health does not reflect the amount of service that Mental Health actually receives from HCSA.

WE RECOMMEND that the County Administrator's Office, HCSA Administration, and Mental Health Administration analyze the amount of service that Mental Health receives from HCSA. If this analysis validates our conclusions, these parties should confer with the Auditor-Controller's Office to determine a new method for distribution of HCSA overhead to Mental Health.

WE CONCLUDE that the rate of administrative support cost is substantially higher in Alameda County Mental Health Service than the average rate of other comparable California Counties.

Administrative support is defined as mental Health Administration costs and county overhead cost (A-87).



WE CONCLUDE that the costs per unit of service for partial day service and outpatient service are considerably higher in the Alameda County Mental Health Service than in numerous other counties. Partial day service as defined here, refers to the State term for Day Treatment and Partial Day. Outpatient service as defined here, refers to the State term for Rehab, Crisis Children Service, Psych Emergency, and outpatient.

As explained in Support, below, other types of service are not comparable. Hence we can make no conclusion regarding this County's cost of inpatient services. Nor can we make any conclusion regarding this County's cost of community service programs (consultation, education and information).

WE CONCLUDE that if total costs remained constant and productivity increased; cost per unit would decrease.

WE CONCLUDE that the additional cost to mental health for outpatient County-operated services located in the County hospitals as compared to County-operated services located elsewhere was \$278,915 in fiscal year 1974-75.

WE CONCLUDE that this additional cost of \$278,915 will continue for all years that the sites presently located in County Hospitals remain in these locations.

A Recommendation on this issue must include consideration and balancing of other issues beyond cost. Our discussion in Volume I, relates the cost conclusions here to issues of quality, impact, productivity and management.

Productivity

Specifically -

WE CONCLUDE that Alameda County Unit costs for outpatient and day treatment services are generally higher than the unit costs reported by the nine other populous California Counties.

WE CONCLUDE that unit costs vary greatly among services within service modalities and that no distinct pattern exists to account for the large variety in costs.

WE CONCLUDE that Alameda County's Mental Health Services - both County-operated and contracted - exhibit great variance in productivity when measured by unallocated staff time. Although a few services display extremely efficient staff utilization, most services have more than half of staff time that is not allocated to direct or in-direct services.

WE CONCLUDE that great variance exists within service modalities regarding the number of clients under the general responsibility of a single clinician.

WE CONCLUDE that, in most cases, active caseloads are reasonably distributed within service modalities and are at levels expected for specific services.

WE RECOMMEND that the Mental Health Service begin immediately to develop and implement a work standard and measurement program than applies equally to County-operated and contract programs. This program, in order to succeed and be conscientiously followed, must be linked to realistic objectives that are sensitive to the unique characteristics of a program and its clientele. The program must also carry out a "bottoms-up" decision-making process that recognizes the contribution of line workers as well as managers.

WE RECOMMEND that the Mental Health Service begin to seriously investigate the feasibility of applying to most services some alternative treatment approaches that are innovative and cost-efficient. Use of clinical teams, home visiting and increased use of group therapy are possible beginning points.

WE RECOMMEND that the Mental Health Service critically examine the results of the productivity study and immediately begin to reallocate staff among service sites in order to increase the cost-efficiency and productivity of services while equalizing workloads. This should be a major County-wide priority. Reallocation decisions should, however, be made with a clear link between staffing and recognized needs.

A. Introduction

1. The Importance of the Issue

Our mental health programs face demands for increased service while the resources available to meet the need have decreased. For Community Mental Health Program in California, the handwriting is clear; State Short-Doyle funding is no longer an endless stream of support. At the same time, the pressures in the County's General Fund are severe, making support beyond the local contribution of 10 percent increasingly difficult.

In this environment, the need to maximize the use of the skilled staff in our County-operated and contracted services must be a major priority. As our resources are squeezed between expanding demands, rising costs, and diminished resources, the productivity of present staff is critical.

2. Organization of Findings: Cost and Productivity

The cost analysis of County-operated and contracted mental health services will be presented first as Chapter I in order to effectively discuss productivity. The productivity analysis follows as Chapter II.

CHAPTER I
COST ANALYSIS

Section I - Development of Total Costs Per Service Site

A. Our Approach

1. Background

To date, the only cost analysis of the Mental Health Service sites in Alameda County is contained in the Cost Reporting/Data Collection (CR/DC) report prepared by HCSA-Finance for submission to the State Department of Health. This cost report includes only Short-Doyle programs and is the basis of reimbursement of Short-Doyle monies.

For numerous reasons, the costs of individual sites presented in the CR/DC report are not comparable. In our cost analysis, we have calculated costs of individual sites in a manner which makes these costs comparable.

1) Mental Health Administration -

This includes Office of the Director, Mental Health Administration, Research and Evaluation, District and NIMH Administration, Rehab, Children and Adult Services Administration.

2) A-87, sometimes referred to as General County Overhead -

This includes two types of overhead costs:

- a) HCSA overhead applicable to Mental Health - Approximately 60 percent of Mental Health A-87 costs are attributable to HCSA overhead.
- b) Other County departments overhead applicable to Mental Health - This includes the various departments which perform services for other County departments and for contracted services. Examples include the Auditor-Controller, County Counsel, County Administrator. Approximately 40 percent of the Mental Health A-87 costs are attributable to other County departments.



2. Criteria and Methodology

We have calculated costs at four different levels for each individual site.

The following outline presents the derivation of costs at each level of calculation, including data sources, basis for distribution of costs to the various sites, and the limitations of each level of calculation.

a. Level I cost is calculated as follows:

The sum of: salaries, wages and benefits
 operating expenses
 other-hospital support
 other - miscellaneous

Note: "Other-hospital support" is charged only to those services located in a County hospital. It includes those services rendered to the service site by the hospital.

Data Sources for Level I include the following:

The CR/DC report for fiscal year 1974-75, and related workpapers were the source of data for all Short-Doyle programs. For revenue-sharing programs, contractors budgets were used. Generally, revenue-sharing budgets do not coincide with the fiscal year. In these instances, the budget which coincides most closely with fiscal year 1974-75 was used. For example, a revenue-sharing budget may go from September, 1974, to August, 1975. Hence, that budget would be used.

Basis of Distribution of Costs: These costs are directly identified with each site, hence, no distribution was necessary.

Limitations of Level I:

This analysis includes rental costs or building depreciation for those contracted services which include these costs in their contract. It



does not include Building Maintenance (BMD) costs for County-operated services in County buildings. Because BMD includes use-allowance, which is similar to depreciation, at this level of analysis County-operated services are understated with respect to cost of buildings.

b. Level II cost is calculated as follows:

To the cost calculated in Level I, add the following -

BMD (Building Maintenance)
Mental Health Administration

Data Sources for Level II include the following:

- 1) BMD was calculated by the Auditor-Controller's Office for fiscal year 1974-75, and represents the actual amount charged to the Mental Health Service. BMD consists of the following costs: maintenance, insurance, use-allowance (comparable to depreciation) and utilities. In fiscal year 1974-75, only those services located in County-operated buildings were charged for BMD.
- 2) Mental Health Administration cost was obtained from HCSA - Finance Division.

Basis of Distribution of Costs:

- 1) BMD was distributed to County-operated services located in County-operated buildings on the basis of salaries, wages, and benefits.
- 2) Mental Health Administration was distributed to all services - 90 percent of Mental Health Administration was distributed to County-operated services and 10 percent was distributed to contracted services. Costs were allocated to the various services on the basis of the total calculated in Level I.



Both contractors and County-operated services receive administration and monitoring from Mental Health Administration. We asked persons in charge of the various Mental Health Administration units (Northern Region, Southern Region, Program Evaluation, Local Director) to informally estimate how much time their unit spends on contractor-related work. Estimates of time spent ranged for 10 percent to 45 percent of total time. In order to make our distribution of Mental Health Administration to contractors conservative, we chose to allocate 10 percent of Mental Health Administration costs to contractors.

Therefore, 10 percent of the Mental Health Administration costs were allocated to the various contractors on the basis of Level I cost. Also 90 percent of the Mental Health Administration costs were allocated to the various County-operated services on the basis of Level I cost.

Limitations of Level II:

This level provides the best comparison of the various services. Therefore, Level II is used in Chapter II, Productivity, for the calculation of costs per unit of service. However, at Level II costs of all services are somewhat understated because no A-87, which includes general County overhead and HCSA overhead, is distributed to any of the services. Some A-87 costs are generated by both County-operated and contracted services but it would be difficult to determine what proportion of these costs are attributable to County-operated services and contracted services. Furthermore, because A-87 costs appear to be inelastic (i.e., insensitive), at least in the short run, to the size of the Mental Health budget, County-operated and contracted services could best be compared if no A-87 was distributed to any of the service sites.

c. Level III cost is calculated as follows:

To the cost calculated in Level II add the following -

Depreciation of equipment for County-operated services.

Data Source for Level III is the following:

Depreciation was calculated by the Auditor-Controller's Office for fiscal year 1974-75, and represents the actual amount charged to the Mental Health Service for equipment located in County-operated services.

Basis of Distribution of Costs:

The Auditor-Controller's Office does not distribute the depreciation cost to the various mental health sites. Instead a lump sum is calculated for the entire Mental Health Service. We have distributed depreciation to each County-operated service on the basis of salaries, wages and benefits.

Limitations of Level III:

Equipment purchased for County-operated mental health services is reimbursed via Short/Doyle. Generally the State will not reimburse for equipment by contracted services. The entire cost of equipment is reported to the State in the year of purchase. In some contracts depreciation costs are included, in others they are not. Because total depreciation costs for all County-operated services in fiscal year 1974-75, is only \$9,000, distribution of this depreciation to the various County-operated facilities does not make any sizable difference in total costs.



d. Level IV cost is calculated as follows:

To the cost calculated in Level III, add the following -

A-87 costs

6

Data Source for Level IV is the following:

A-87 costs charged to Mental Health for fiscal year 1974-75 were obtained from HCSA - Finance.

Basis of Distribution of Costs:

A-87 was distributed only to County-operated services. It was distributed on the basis of salaries, wages and benefits.

Limitations of Level IV:

If A-87 costs are added to County-operated services, total costs are not comparable to contracted services total costs. The reason for this is that some A-87 costs are generated by contracted services. However, it is difficult to determine how much is generated by contracted services.

It is also important, when looking at level IV, to keep in mind that A-87 costs are somewhat inelastic; a sizable reduction of the total Mental Health budget probably would not decrease A-87 costs. These costs would simply be distributed to the other departments which are apportioned A-87 costs.

B. Findings - Individual Site Costs

Refer to Table I for costs calculated at each of the forementioned levels.

Sub-totals I, II and II and Total refer to levels I, II, III and IV, respectively.



-11-

Table I
COSTS PER SERVICE SITE

NAME OF SITE	Salaries	Wages and Benefits	Operating Expenses	Other Hospital Support	Other Misc.	SUB-TOTAL I	Mental Health Administration	BMD	SUB-TOTAL II	Depreciation	SUB-TOTAL III	General County Overhead	TOTAL
East Oakland Crisis	\$ 279,832	\$ 66,841	\$ 18,542	\$ 0	\$ 365,215	\$ 72,443	\$ 6,542	\$ 444,200	\$ 662	\$ 444,862	\$ 90,465	\$ 535,327	
West Oakland Crisis	53,285	12,343	0	5,268	70,896	2,836	0	73,732	0	73,732	0	73,732	
North Oakland Crisis	35,316	12,699	0	10,747	58,762	2,350	0	61,112	0	61,112	0	61,112	
East Oakland Family H.C.	107,464	18,699	0	0	126,163	5,047	0	131,210	0	131,210	0	131,210	
Eden Crisis	102,377	39,517	7,392	0	149,286	29,857	2,352	181,495	189	181,684	25,847	207,531	
Valley Crisis	74,990	63,706	0	0	138,696	27,739	0	166,435	189	166,624	25,847	192,471	
Tri-City Crisis	118,985	8,212	0	0	127,197	25,439	0	152,636	284	152,920	38,771	191,691	
Central Crisis	112,580	91,060	23,625	0	227,265	45,453	2,646	275,364	284	275,648	38,771	314,419	
El Centro de Salud Mental	198,744	26,573	0	0	225,317	9,012	0	234,329	0	234,329	0	234,329	
Berkeley Crisis	43,132	19,373	0	4,837	67,342	2,694	0	70,036	0	70,036	0	70,036	
Berkeley Rehab	23,193	10,893	0	2,316	36,402	1,456	0	37,858	0	37,858	0	37,858	
Eden Rehab	148,771	62,795	4,054	0	207,512	41,502	0	249,014	378	249,392	51,694	301,086	
West Oakland Rehab	73,745	20,406	0	7,678	101,829	4,073	0	105,902	0	105,902	0	105,902	
Valley Rehab	29,560	14,120	0	0	43,680	8,736	0	52,416	66	52,482	9,047	61,524	
East Oakland Rehab	247,022	35,336	0	0	282,358	56,472	0	338,830	568	339,398	77,542	416,940	
Tri-City Rehab	99,950	47,954	0	0	147,904	29,581	0	177,485	189	177,674	25,847	203,521	
Central Rehab	113,171	7,667	26,016	0	146,854	29,371	2,646	178,871	284	179,155	38,771	217,926	
Eden Day Treatment	139,464	66,037	52,174	0	257,675	51,535	3,234	312,444	289	312,733	39,411	352,150	
Central Day Treatment	85,822	21,583	19,078	0	126,483	25,297	1,985	153,765	189	153,954	25,847	179,801	
*Gladman Day Treatment	NA	NA	0	NA	160,000	6,400	0	166,400	0	166,400	0	166,400	
West Oakland Day Treatment	48,547	18,729	0	11,548	78,824	3,153	0	81,977	0	81,977	0	81,977	

* CR/DC Breakdown of total costs not compatible with our classifications



COSTS PER SERVICE SITE (Cont'd)

NAME OF SITE	Salaries	Operating Expenses	Other Hospital Support	Other-Misc.	SUB-TOTAL I	Mental Health Administration		SUB-TOTAL II	Depreciation	SUB-TOTAL III	General County Overhead	TOTAL
	Wages and Benefits					BMD						
Fred Finch Day Treatment	\$ 80,500	\$ 18,929	\$ 0	\$ 44	\$ 99,473	\$ 3,979	\$ 0	\$ 103,452	\$ 0	\$ 103,452	\$	\$ 103,452
Berkeley Day Treatment	73,932	21,496	0	7,704	103,132	4,125	0	107,257	0	107,257		107,257
Ann Martin	75,876	13,735	0	0	89,611	3,584	0	93,195	0	93.195		93.195
Central Child Development	135,460	20,997	0	0	156,457	31,291	0	187,748	284	188,032	38,771	226,803
Valley Child Development	41,199	1,570	0	0	42,769	8,554	0	51,323	95	51,418	12,924	64,342
Tri-City Child Development	93,846	24,716	0	0	118,562	23,712	0	142,274	189	142,463	25,847	168,310
East Bay Activity Center **	NA	NA	0	0	107,316	4,293	0	111,609	0	111,609		111,609
Eden Children's Service	105,863	44,862	16,351	0	167,076	33,415	2,499	202,990	189	203,179	25,847	229,026
Lincoln Child Center **	NA	NA	0	NA	125,844	5,034	0	130,878	0	130,878	0	130,878
Probation Guidance Clinic	330,655	3,635	0	0	334,290	66,858	7,718	408,866	757	409,623	103,389	513,012
Alameda Clinic	101,395	34,247	0	0	135,642	27,128	0	162,770	241	163,011	32,955	195,966
Fred Finch Youth Center **	NA	NA	0	NA	397,836	15,913	0	413,749	0	413,749	0	413,749
Highland Psych. Inpatient	1,020,705	104,905	536,465	0	1,662,075	332,415	23,741	2,018,231	2,242	2,020,473	306,289	2,326,762
Highland Psych. Emerg'y	602,508	143,167	107,494	0	853,169	170,634	14,039	1,037,842	1,324	1,039,166	180,930	1,220,096
Fairmont Psych. Emerg'y	262,685	16,512	17,195	0	296,392	59,278	6,101	361,771	568	362,339	77,542	439,881
Mental Health Advocates	49,919	20,014	0	0	69,933	2,797	0	72,730	0	72,730	0	72,730
Asian C.M.H.S.	103,038	24,947	0	0	127,985	5,119	0	133,104	0	133,104	0	133,104
Twin Valley Counseling	33,524	3,060	0	0	36,584	1,463	0	38,047	0	38,047	0	38,047
Suicide Prevention	63,592	25,217	0	0	88,809	3,552	0	92,361	0	92,361	0	92,361
Parental Stress	90,073	32,463	0	0	122,536	4,899	0	127,435	0	127,435	0	127,435

** CR/DC breakdown not available for Short-Doyle portion of total program.



C. Critique of HCSA Overhead Costs Charged to Mental Health for Purposes of State Reimbursement.

WE CONCLUDE that the present amount of HCSA overhead charged to Mental Health is overstated, i.e., the amount of overhead charged to Mental Health does not reflect the amount of service that Mental Health actually receives from HCSA.

WE RECOMMEND that the County Administrator's Office, HCSA Administration, and Mental Health Administration analyze the amount of service that Mental Health receives from HCSA. If this analysis validates our conclusions, these parties should confer with the Auditor-Controller's Office to determine a new method for distribution of HCSA overhead to Mental Health.

SUPPORT:

Our analysis included interviews with numerous County and State personnel. As a result of our analysis, we conclude that Mental Health is charged for more HCSA overhead than it is actually receiving.

Mental Health is charged 23 percent of HCSA overhead. It is difficult to justify that Mental Health is actually receiving that much service from HCSA. HCSA-Finance is one of the few HCSA departments which can be identified as having at least a moderate amount of its workload attributable to Mental Health. One interviewee in Mental Health Administration cited a work study analysis prepared by Finance which indicated that 11 percent of its time was spent on Mental Health work. While Mental Health is charged 23 percent of HCSA overhead costs, one of the few departments within HCSA which can be identified as rendering Mental Health a moderate amount of service indicated that 11 percent of its time was spent on Mental Health.



The issue of how much HCSA overhead is charged to Mental Health is of major importance to Mental Health. Sixty percent of general county overhead (A-87), charged to Mental Health is HCSA overhead. The State of California has refused to reimburse this county at the usual rate of 90 percent of A-87 costs charged to Mental Health. The State believes that A-87 costs in this County charged to Mental Health are too high. Whereas, the A-87 costs charged to Mental Health are approximately \$1.3 million, the State will only recognize approximately \$500,000 in the budget submitted by Mental Health to the State.

Therefore, by reducing the amount of HCSA overhead charged to Mental Health, A-87 costs to Mental Health are reduced and are therefore more acceptable to the State.

The amount of HCSA overhead currently charged to Mental Health is not a cost of Mental Health and should be reduced to reflect that cost.



Section II - A Comparison of Alameda County Mental Health Service Costs to
Other California Mental Health Services

Part I - A Comparison of the Rate of Administrative Support Costs

WE CONCLUDE that the rate of administrative support cost is substantially higher in the Alameda County Mental Health Service than the average rate of other comparable California Counties.

Administrative support is defined as Mental Health Administration costs and county over head costs (A-87).

SUPPORT:

Table II presents the total costs of administrative support and gross program in numerous large California Counties. Table III presents the rate of administrative support cost to gross program cost in those same counties.

General county overhead, (A-87), represents administrative support costs which cannot be directly attributed to a program, and therefore, cannot be directly charged to that program. These costs are apportioned to programs using the Federal guidelines known as A-87.

General county overhead is not comparable between counties. This is because costs in some counties may be charged directly and in other counties these costs may be apportioned to programs.

However, a comparison of administrative support costs among counties is valid. As indicated in Table III, the Alameda County Mental Health Service has a much larger percentage of administrative support costs than do most other counties.

Table II

COMPARISON OF COMMUNITY MENTAL HEALTH COSTS

FISCAL YEAR 1974-75

	<u>ALAMEDA</u>	<u>SAN MATEO</u>	<u>SANTA CLARA</u>	<u>SAN DIEGO</u>	<u>RIVERSIDE</u>	<u>CONTRA COSTA</u>	<u>SAN BERNARDINO</u>	<u>FRESNO</u>	<u>ORANGE</u>	<u>LOS ANGELES</u>
<u>ADJ. GROSS COST</u>	\$ 11,807,683	\$ 10,280,532	\$ 14,192,451	\$ 12,274,408	\$ 7,577,516	\$ 6,549,642	\$ 6,082,799	\$ 5,752,261	\$ 15,114,757	\$ 60,807,772
ADM. SUPPORT COUNTY OVERHEAD	\$ 2,509,682	\$ 717,913	\$ 1,564,908	\$ 1,178,173	\$ 307,028	\$ 520,319	\$ 1,458,273	\$ 775,241	\$ 1,057,195	\$ 2,583,771
<u>COMMUNITY SERVICE PROGRAM</u>										
ADJ. GROSS COST PROF. HOURS OF SERVICE COST PER UNIT OF SERVICE	\$ 1,456,129 68,551 \$ 21.24	\$ 1,455,793 61,230 \$ 23.78	\$ 1,282,946 68,523 \$ 18.72	\$ 708,989 44,882 \$ 15.80	\$ 662,774 69,734 \$ 9.04	\$ 712,581 28,452 \$ 25.04	\$ 625,355 67,598 \$ 9.25	\$ 473,362 35,757 \$ 13.24	\$ 606,694 65,702 \$ 10.15	\$ 3,249,537 57,322 \$ 56.69
<u>DAY TREATMENT PROGRAM</u>										
<u>DAY CARE</u>										
ADJ. GROSS COST PATIENT DAYS COST PER UNIT OF SERVICE	\$ 2,878,045 43,506 \$ 65.15	\$ 2,999,181 23,939 \$ 125.28	\$ 4,635,721 59,686 \$ 77.67	\$ 5,161,972 48,547 \$ 106.33	\$ 3,723,078 37,262 \$ 99.92	\$ 1,895,390 19,920 \$ 95.15	\$ 2,232,669 15,684 \$ 142.35	\$ 1,338,441 12,871 \$ 103.99	\$ 3,775,455 50,167 \$ 67.22	\$ 21,973,570 185,184 \$ 113.26
<u>PARTIAL DAY CARE</u>										
ADJ. GROSS COST PATIENT DAYS COST PER UNIT OF SERVICE	\$ 1,072,515 20,111 \$ 53.33	\$ 1,479,390 57,682 \$ 25.65	\$ 2,637,072 134,542 \$ 19.60	\$ 1,276,434 39,470 \$ 32.34	\$ 446,666 17,219 \$ 25.94	\$ 1,847,686 48,333 \$ 38.23	\$ 596,633 27,250 \$ 21.89	\$ 1,039,940 26,899 \$ 38.00	\$ 4,168,141 89,517 \$ 46.57	\$ 7,995,211 271,352 \$ 29.50
<u>CITATIONS</u>										
ADJ. GROSS COST PATIENT VISITS COST PER UNIT OF SERVICE	\$ 5,995,470 82,286 \$ 72.86	\$ 3,460,976 95,906 \$ 36.09	\$ 5,108,342 230,942 \$ 22.12	\$ 4,697,418 126,082 \$ 37.26	\$ 2,599,043 94,110 \$ 27.62	\$ 2,040,485 48,450 \$ 41.12	\$ 2,233,708 103,249 \$ 21.63	\$ 2,510,785 51,522 \$ 45.78	\$ 5,959,510 203,587 \$ 29.27	\$ 31,903,267 780,598 \$ 40.87

County & Hospital Resources
Patient Benefits & Accounts Section
March 11, 1976

SOURCE: State Department of Health

Table III

<u>COUNTY</u>	RATE OF ADMINISTRATIVE SUPPORT TO GROSS PROGRAM COST
Alameda	21%
Average of Counties listed below	9.8%
San Mateo	7%
Santa Clara	11%
San Diego	10%
Riverside	4%
Contra Costa	8%
San Bernardino	24%
Fresno	13%
Orange	7%
Los Angeles	4%

SOURCE: State Department of Health for fiscal year 1974-75.

Part 2 - A Comparison of Cost Per Unit of Service

WE CONCLUDE that the costs per unit of service for partial day service and outpatient service are considerably higher in the Alameda County Mental Health Service than in numerous other counties. Partial day service, as defined here, refers to the State term for Day Treatment and Partial Day. Outpatient service as defined here, refers to the State term for Rehab, Crisis, Children Service, Psych Emergency, and outpatient.

As explained in SUPPORT, below, other types of service are not comparable. Hence, we can make no conclusion regarding this County's cost of inpatient services. Nor can we make any conclusion regarding this County's cost of community service programs, (consultation, education and information).

WE CONCLUDE that if total costs remained constant and productivity increased cost per unit of service would decrease.

SUPPORT:

The types of service presented in Tables II and IV, are those used by all California Counties in preparation of the Cost Reporting/Data Collection (CR/DC) report which is submitted to the State.

The costs of partial day service and outpatient service are the only types of service costs which are comparable among the various counties. This is because these services are provided by similar providers.

By way of contrast, consider 24-hour care. 24-hour care is not comparable among the various counties because services are not provided by similar providers. 24-hour care may range from a half-way house setting to a hospital inpatient setting. The costs of these two types of facilities are vastly different. For example, in this County, a unit of inpatient care costs approximately 20 times that of a unit of half-way house care.

Hence, any comparison of the cost of 24-hour care among the various counties is a comparison of the mix of providers used by those counties.

Likewise, community service programs, (CEI), are not comparable because these services are also provided by dissimilar providers.

Refer to Table IV. Note that unit costs of partial day service and outpatient service are respectively 72 percent and 117 percent higher than the average costs of the other large California counties.

Unit costs can be higher due to several factors - total costs may be relatively higher and/or productivity may be relatively lower than in other counties.

Our analysis confirms that this Mental Health Service's administrative support costs are higher than in most other counties. This influence this County's cost per unit of service. Also Chapter II, Productivity, indicates certain facilities which have very low productivity. While we do not know how this County compares with others with respect to productivity, one thing is certain: if total costs remained constant and productivity increased, cost per unit of service would decrease.



TABLE IV
A COMPARISON OF COST PER UNIT OF SERVICE

<u>County</u>	type of service			<u>Outpatient</u>
	<u>Community Service Program</u>	<u>treatment program</u>	<u>Partial Day</u>	
	<u>24-hour</u>			
Alameda	\$21.24	\$ 66.15	\$53.33	\$72.86
Average of Counties listed below	\$20.19	\$103.46	\$30.93	\$33.53
San Mateo	\$23,78	\$125.28	\$25.65	\$36.09
Santa Clara	\$18.72	\$ 77.67	\$19.60	\$22.12
San Diego	\$15.80	\$106.33	\$32.34	\$37.26
Riverside	\$ 9.04	\$ 99.92	\$25.94	\$27.62
Contra Costa	\$25.04	\$ 95.15	\$38.23	\$41.12
San Bernardino	\$ 9.25	\$142.35	\$21.89	\$21.63
Fresno	\$13.24	\$103.99	\$38.66	\$45.78
Orange	\$10.15	\$ 67.22	\$4 .57	\$29.27
Los Angeles	\$56.69	\$113.26	\$29.50	\$40.87

SOURCE: State Department of Health.

Note: For purposes of comparison, data supplied by SDH, was used here for all counties. Therefore, the above unit costs for Alameda County do not reflect the unit costs calculated in our analysis of Productivity, Chapter II.

Section III - What is the Additional Cost to Mental Health for Out-Patient Services Located in the County Hospitals as Compared to Services Located Elsewhere?

WE CONCLUDE that the additional cost to mental health for out-patient County-operated services located in the County hospitals as compared to County-operated services located elsewhere was \$278,915 in fiscal year 1974-75.

WE CONCLUDE that this additional cost of \$278,915 will continue for all years that the sites presently located in County hospitals remain in these locations.

A Recommendation on this issue must include consideration and balancing of other issues beyond cost. Our discussion in Volume I relates the cost conclusions here to issues of quality, impact, productivity and management.

SUPPORT:

A. Approach

1. Background

During our overview process, many persons indicated that mental health could save money if those services now located in a County hospital were relocated elsewhere in the community. Our analysis confirms this for out-patient services. However, our analysis did not include the in-patient unit or the psychiatric emergency facilities. Some might argue that it would not be feasible to remove these facilities from the County hospitals. We wished to include only those services in our analysis which most people would agree could function well outside of the hospital.

2. Criteria and Methodology

Early in our evaluation we hoped to pursue an "opportunity cost" approach, i.e., given the cost of space and services now charged to sites located in the hospitals, what would be the cost of equivalent services obtained in the private sector?

In Table I, other hospital support refers to those costs charged to a site by the hospital. Note: this cost is only for those sites located in a



County hospital.

From HCSA-Finance, we obtained a breakdown of costs charged to sites within the hospitals. These costs are referred to as "Step-down costs". The Step-down costs include numerous costs charged to Mental Health. We present a partial list of the Step-down costs: security, data processing, central collections, operation of plant, laundry and linen, dietary, medical records, and cafeteria.

In order to pursue an opportunity cost approach, we raised the following questions:

1. Is Mental Health actually receiving the various services for which it is charged?
2. If so, does Mental Health need to use those various services, for which it is charged?
3. Could Mental Health obtain equivalent services elsewhere for less money?

During the course of our analysis, these questions were not answered to our satisfaction. Hence, we were unable to pursue an opportunity cost approach. Refer to Table V, which indicates that general expenses often are higher for those sites located in a County hospital. For purposes of this section, we define general expenses as operating expenses, other-hospital support, other-miscellaneous costs, and BMD. These amounts are presented in Table I and are included in Sub-Total II costs for each individual site.

As another approach to the additional cost to Mental Health for services located in the County hospitals, we examined the rate of general expenses to salaries, wages and benefits.

B. Findings

Note that rate of general expenses for out-patient services located in County hospitals is approximately 30 percent higher than the rate of County-operated services located elsewhere.

If those out-patient sites located in the County hospitals had the same general expense rate as other County-operated services, the yearly savings to Mental Health would be \$278,915

* CALCULATION:

total salaries, wages and benefits for out-patient services located in County hospitals: \$939,109 (source-Chart I);

difference in rate of general expense equals 29.7%.

$$(59.2\% - 29.5\% = 29.7\%)$$
$$\$939,109 \times 29.7\% = \$278,915$$

Contracted services are not included in Table V because some contractors may include certain salaries and wages under general expense categories. Hence, a comparison of rate of general expense to salaries, wages, and benefits between certain contracted services and other services would not be totally valid.

Because the costs charged to Mental Health by the hospitals in fiscal year 1974-75, are indicative of costs charged in other years, the higher rate of general expenses will continue for sites located in the County hospitals. Hence, the additional cost to Mental Health of \$278,915 will continue each year that the mental health sites located in the hospitals, in fiscal year 1974-75, continue to remain in Fairmont and Highland Hospitals.

Table V

Rate of *General Expenses to Salaries, Wages, and Benefits

SITE:

PERCENTAGE

County-Operated Services

Located in a County Hospital -
Out-Patient Facilities:

East Oakland Crisis	32.9%
Eden Crisis	48.1%
Central Crisis	104.2%
Central Rehab	32.1%
Eden Day Treatment	87.1%
Central Day Treatment	50.0%
Eden Children's Service	60.2%
<u>AVERAGE</u>	<u>59.2%</u>

Other facilities:

Highland Psych Inpatient	65.2%
Highland Psych Emergency	43.9%
Fairmont Psych Emergency	15.2%
<u>AVERAGE</u>	<u>41.4%</u>

Not Located in a County Hospital -

Valley Crisis	85.0%
Tri-City Crisis	6.9%
Eden Rehab	39.5%
Valley Rehab	47.8%
East Oakland Rehab	14.3%
Tri-City Rehab	48.0%

6

7

8

Table V - (Cont'd)

Not Located in a County Hospital - (Cont'd)

Central Child Development	15.5%
Valley Child Development,	3.8%
Tri-City Child Development	26.3%
Probation Guidance Clinic	3.4%
Alameda Clinic	33.8%
<u>AVERAGE</u>	<u>29.5%</u>

SOURCE: Table I

* General Expenses defined as operating expenses, other-hospital support,



CHAPTER II

PRODUCTIVITY

A. Our Approach

1. Background

Our discussion of productivity is designed around specific quantitative measures, which, if used together, yield a composite picture that can be interpreted in light of other issues addressed in this evaluation. Our measures deal with the factors that can affect productivity.

Problems in productivity can stem from a number of different sources: high cost for a specific service, when coupled with low caseloads and few staff yield a high cost for each unit of service provided. Confusion over the goals and objectives of a program means wasted staff time. Demand for services may be limited if a program is located where parking is difficult or far from the mainstream of the community it is supposed to serve. As always, management decisions on staff allocation also affect productivity, as does leave taken for vacation and illness.

2. Measures and Methodology

The following measures were used to gain information on the productivity of each of 37 mental health service sites.

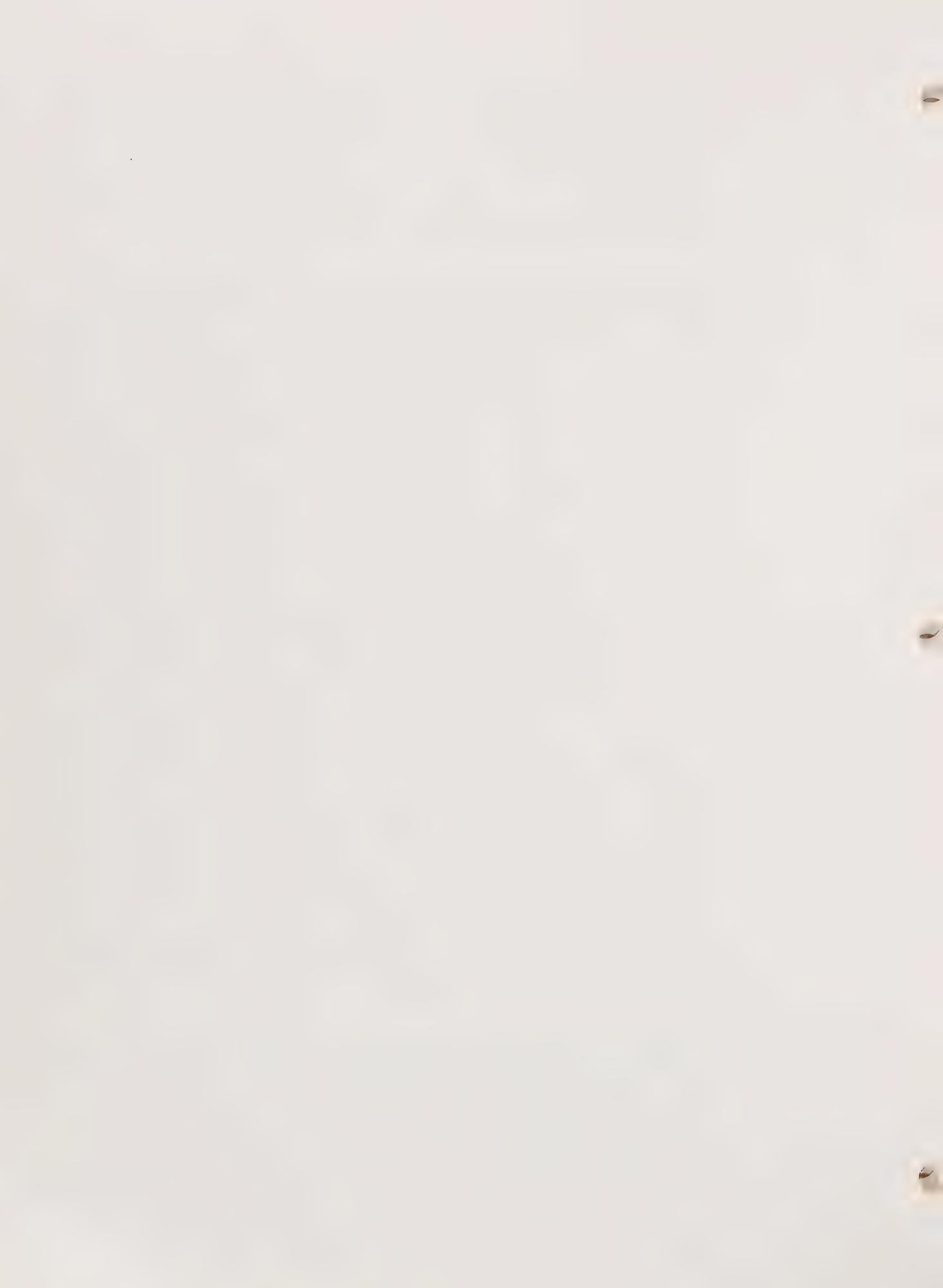
- a) The Cost Per Unit of Direct and Indirect Service is a relative measure of what amount of total resources are needed to yield a single unit of service (an hour of treatment or any form of consultation, for example).

The cost of providing similar services can be reasonably compared using unit costs. Our unit cost estimates



are based upon activity reported to OPE through questionnaires, the Global Assessment Scale reports and in the 1975-76 biostats, thus the numbers are slightly different from those used to make county-by-county comparisons⁹ in Table III.

- b) The Number of Unallocated Professional Staff Hours Per Average Month is a relative measure of how many staff hours, on average, are absorbed in providing direct and indirect services. A service that has a very high proportion of unallocated time could be providing the same level of services with fewer staff or could conceivably provide a greater quantity of service with the same staff. Staff time is also legitimately spent in such additional activities as administration, attending meetings and case conferences, receiving and providing clinical supervision and training, planning programs, performing intake and client advocacy, as well as sick leave, holidays and vacations. The results of the OPE time distribution estimates, reported to us by all professional staff, indicate that many of these activities tend to occupy a total of between 4 and 13 hours per average clinician in a typical month. OPE feels this figure is very conservative and should not represent the total "residual" time available in a typical week since the 4 to 13 hour spread does not include estimated time for holidays, vacations, sick leave and breaks.
- c) The Ratio of Clinicians to Clients is a relative measure of how total caseloads and staffing patterns translate into average clinicians responsibilities for direct treatment or supervision. This measure is helpful in developing comparisons across and within modalities in terms of frequency of contact and level of effort.



d) Caseload Comparisons is a relative measure of total activity of a given service or modality in the provision of direct treatment. Like clinician/client ratios, caseload comparisons are useful in developing comparisons across and within modalities on level of effort. The analysis breaks down the caseload data into three parts:

- 1) Number of total, open chart cases;
- 2) The number of total cases that are, in fact, active cases and
- 3) The number of active cases that require ✓ maintenance (i.e., medication) only.

Each of these four measures provides a single narrow window from which to view productivity. However, when taken in combination, a broader, more accurate assessment is possible. These windows for viewing productivity were developed as follows:

METHODOLOGY

a) The cost per unit of direct and indirect service was derived by dividing the total amount of clinician time utilized per client in one-time units, direct treatment, and consultation activity by the true total cost of each service site as derived in Chapter I (costs). Where discrepancies existed between several sources of time distribution data, OPE used the most reliable data that reflected the largest amount of activity reported by the service site.

- 1) Direct treatment time: a) hours estimated by each clinicians for each client as part of the Global Assessment Scale reports requested by OPE; b) where GAS data was incomplete or unavailable, clinician estimates of time utilization, from staff questionnaires or biostats were used.



- 2) Drop-in time: Hours (visits) as reported in the July-December, 1975 biostats prepared by the Program Evaluation Unit of the Mental Health Service.
- 3) Consultation time: a) Hours (visits) as reported in the July-December, 1975 biostats prepared by the Program Evaluation Unit of the Mental Health Service. The areas included under the "Community Services" category include time spent in consultation with outside agencies and between other services, community education, "information only" services, liaison and placement activities, including telephone time; b) Where necessary, clinician estimates of time utilization, from staff questionnaires, and biostats were used.
- 4) Total Cost:

OPE cost analysis (Chapter I)

- b) The Number of Unallocated Professional Staff Hours Per Average Month was derived by adding together the total amount of monthly staff time available per site (weekly hours per clinician x 4.25 for all staff in each site: See Appendix) and subtracting from the average monthly total of staff hours available the total average hours per month spent in direct and indirect services. Where discrepancies existed between several sources of time distribution data, OPE used the most reliable data that reflected the largest amount of activity. Monthly unallocated time - in hours per site - was divided into the total monthly staff hours available to yield a percentage of time that is unallocated to direct or indirect service in an average month.

Data Sources -

1. Direct Treatment Time - a 1 Above
2. Drop-In Time - a 2 Above
3. Consultation Time - a 3 Above



- c) The Ratio of Clinicians to Clients was derived by dividing the total number of clients directly served by a given site by the⁹ total number of equivalent full-time staff in the site who reported serving active caseloads.

Data Sources -

1. Number of clients receiving direct treatment hours, by clinician: OPE data from Global Assessment Scale reports.
2. Number of full-time equivalent clinicians providing direct treatment hours: OPE data from Global Assessment Scale reports.

- d) Caseload Comparisons were derived by totaling caseload data collected from each site as part of the Global Assessment Scale reports.

Data Sources -

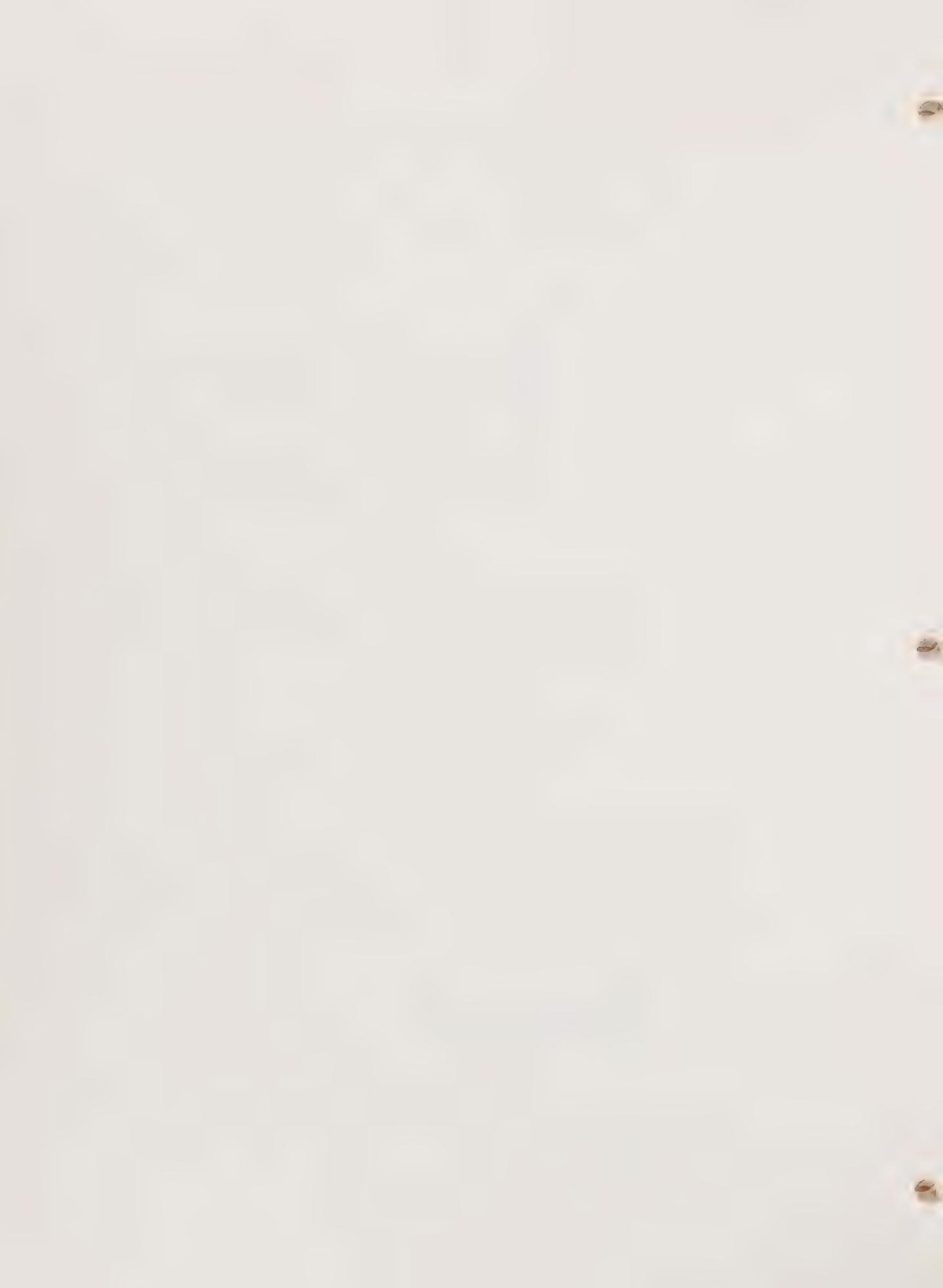
1. Global Assessment Scale reports.

3. Organization of Findings

The findings, conclusions, and recommendations for each of the four productivity measures is under a separate heading under Section B.

- B 1: Unit Cost
- B 2: Unallocated Staff Time
- B 3: Clinician/Client Ratios
- B 4: Caseload Comparisons

Section C provides a general assessment and Section D outlines our recommendations.



B. Findings and Conclusions

1. Unit Costs

A unit cost is that amount of funds necessary to provide one unit of service - whether it be a single visit, hour of therapy or consultation.

WE CONCLUDE that Alameda County unit costs for crisis/outpatient and day treatment services are generally 60% higher than the unit costs reported by the nine other populous California counties.

SUPPORT:

According to State Department of Health statistics for Fiscal Year 1974-75, Alameda County unit costs are among the highest in the State. Table IV displays the unit costs by type of service for the 10 most populous California counties. These costs comparisons are based on directly comparable data reported to the State Department of Health through annual CR/DC Reports.

WE CONCLUDE that unit costs vary greatly among services within service modalities and that no distinct pattern exists to account for the large variety in costs.

SUPPORT:

Our analysis (see Table VI) reveals that the disparity in unit costs between services within the same modality is extreme. To illustrate, the following average and range (low to high):

- a) Crisis Adult Outpatient Services
Average Unit Cost: \$48.46
Range: from \$13.17 (El Centro de Salud Mental)
to \$125 (Eden Crisis)



- b) Rehab Services
Average Unit Cost: \$23.66
Range: from \$11.32 (Central Rehab)
to \$39.65 (Tri-City Rehab)
- c) Day Treatment Services
Average Unit Cost: \$30.31
Range: from \$10.23 (Berkeley Day Treatment)
to \$51.93 (Fred Finch Day Treatment) or
to \$50.07 (Eden Day Treatment)
- d) Children's Services
Average Unit Cost: \$40.68
Range: from \$17.82 (Valley Child Development)
to \$62.86 (Probation Guidance Clinic)

2. Amount of Unallocated Staff Time Per Average Month

Unallocated staff time is that amount of staff time each month that is not spent in direct or indirect (consultation) services.

WE CONCLUDE that Alameda County's Mental Health Services - both County-operated and contract - exhibit great variance in productivity when measured by unallocated staff time. Although a few services display extremely efficient staff utilization, most services have more than half of staff time that is not allocated to direct or indirect services.

SUPPORT:

Table VI summarizes the results of our productivity findings. The results for unallocated time are shown in the second column along with a bar graph to display the variance. To illustrate the findings, the average and range of staff time unallocated per month is highlighted below as a percentage.

- a) Crisis/Adult Outpatient Services
Average: 48%
Range: from 16% (El Centro) to 77%
(East Oakland Crisis)
- b) Rehab Services
Average: 53%
Range: from 15% (Central Rehab) to
76% (Hayward CCSS) and 64%
(Eden Rehab)

c) Day Treatment Services
Average: 45%
Range: from 9% (Berkeley Day Treatment)
to 62% (Eden Day Treatment)

d) Children's Services
Average: 54%
Range: from 32% (Lincoln Child Center)
to 65% (Probation Guidance Clinic)
and 62% (Central and Valley C.D.S.)

It goes without saying that all Mental Health Services - indeed all organizations - have some time each month that must go toward activities that are not directly focused on services; people take vacations, get ill, go on educational leave, attend meetings, receive and give training, and do administrative work. However, one must question the productivity of a service in which more than 50% of all available staff time is not allocated to direct or indirect service. Yet, among the County and contract services in Alameda County studied, 19 out of 32 (59%) services exhibited unallocated service time of over 50%. And another 7 of the 32 had unallocated time between 30 and 49%. Yet, most clinicians - 67% - reported in the staff surveys that their workload was "about right;" only 16% stated that they could handle more work.

The results of our study of unallocated staff time represents a very serious situation for the managers of all mental health services. While resources are limited and demands are increasing,

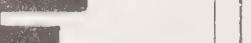
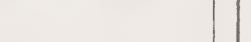
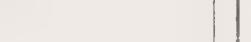
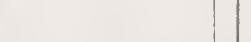
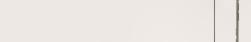
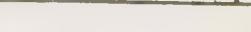


TABLE VI

PRODUCTIVITY: Comparison of Unit Costs, Percentage of Staff Time Unallocated Per Month,
Clinician/Client Staffing Ratios and Active Cases - By Modality and Site

	Name of Site	Average Unit Cost (Direct and Indirect Service)	Percentage of Staff Time Unallocated Per Average Month		Clinician/Client Ratios	Number of Active Cases (12/75) Direct Treatment Only and Percentage of Total	
			Percent	Bar Graph		Number	Percent of Total
				10 0	30 20	50 40	70 60
Adult Outpatient ("Crisis Services")	East Oakland Crisis	\$ 74.18	77%		1:12.38	161	77%
	West Oakland Crisis	\$ 26.63	71%		1:13.88	118	98%
	North Oakland Crisis	\$ 26.63	28%		1:22.00	44	56%
	East Oakland Family H.C.	\$ 28.04	67%		1:10.00	70	89%
	Eden Crisis	\$125.00	62%		1:16.00	32	31%
	Valley Crisis	\$ 35.84	47%		1:24.20	109	98%
	Tri-City Crisis	\$ 24.41	42%		1:18.18	100	77%
	Central Crisis	\$ 27.19	20%		1:20.00	133	78%
	El Centro de Salud Mental	\$ 13.17	16%		1:9.91	113	93%
	Berkeley Crisis	\$103.48	NA		NA	NA	NA
Rehab Services	MODALITY MEAN	\$ 48.46	48%		1:16.28	98	77%
	Berkeley Rehab	\$ 19.84	79%		1:7.33	33	87%
	Hayward CCSS	NA	76%		1:30.91	170	96%
	Eden Rehab	\$ 35.23	64%		1:15.90	159	97%
	West Oakland Rehab	\$ 19.57	56%		1:20.50	123	99%
	Valley Rehab	\$ 23.48	54%		1:22.50	57	92%
	East Oakland Rehab	\$ 16.56	41%		1:18.00	325	90%
	Tri-City Rehab	\$ 39.65	35%		1:24.29	85	79%
	Central Rehab	\$ 11.32	15%		1:14.84	141	95%
	MODALITY MEAN	\$ 23.66 w/o CCSS	53%		1:19.28	137	92%



	Name of Site	Average Unit Cost (Direct and Indirect Service)	Percentage of Staff Time Unallocated Per Average Month				Clinician/Client Ratios	Number of Active Cases (12/75) Direct Treatment Only and Percentage of Total		
			Percent							
			Bar Graph							
Day Treatment Services	Eden Day Treatment	\$50.07	62%	 0 10 20 30 40 50 60 70 80 90 100				1:3.5 28 100%		
	Central Day Treatment	\$27.15	55%	 0 10 20 30 40 50 60 70 80 90 100				1:5.72 38 97%		
	Gladman Day Treatment	\$21.91	52%	 0 10 20 30 40 50 60 70 80 90 100				1:4.61 35 100%		
	West Oakland Day Treatment	\$20.58	51%	 0 10 20 30 40 50 60 70 80 90 100				1:10.75 43 95%		
	Fred Finch Day Treatment	\$51.93	40%	 0 10 20 30 40 50 60 70 80 90 100				1:8.00 NA NA		
	Berkeley Day Treatment	\$10.23	9%	 0 10 20 30 40 50 60 70 80 90 100				1:2.43 17 94%		
Children's Services	MODALITY MEAN	\$30.31	45%	 0 10 20 30 40 50 60 70 80 90 100				1:5.84 32 97%		
	Ann Martin	\$51.16	NA	 0 10 20 30 40 50 60 70 80 90 100				1:5.50 NA NA		
	Central Child Dev'	\$33.29	62%	 0 10 20 30 40 50 60 70 80 90 100				1:8.96 69 87%		
	Valley Child Dev'	\$17.82	62%	 0 10 20 30 40 50 60 70 80 90 100				1:11.45 45 96%		
	Tri-City Children and Youth	\$43.91	59%	 0 10 20 30 40 50 60 70 80 90 100				1:13.50 54 96%		
	East Bay Activity Center	\$56.03	51%	 0 10 20 30 40 50 60 70 80 90 100				1:8.00 NA NA		
	Eden Children's Service	\$28.72	45%	 0 10 20 30 40 50 60 70 80 90 100				1:17.38 113 94%		
	Lincoln Child Center	\$31.61	32%	 0 10 20 30 40 50 60 70 80 90 100				1:3.33 NA NA		
	Probation Guidance Clinic	\$62.86	65%	 0 10 20 30 40 50 60 70 80 90 100				NA NA NA		
Integrated Clinic	MODALITY MEAN	\$40.68	54%	 0 10 20 30 40 50 60 70 80 90 100				1:9.73 70 93%		
	Alameda Clinic	\$11.78	6%	 0 10 20 30 40 50 60 70 80 90 100				1:11.3 136 47%		
Other	Fred Finch Youth Center	\$128.65	61%	 0 10 20 30 40 50 60 70 80 90 100				1:3.75 NA NA		
	Highland Psych Inpatient	\$164.92	NA	 0 10 20 30 40 50 60 70 80 90 100						
	Highland Psych. Emergency	\$135.14	NA	 0 10 20 30 40 50 60 70 80 90 100						
	Fairmont Psych. Emergency	\$133.37	NA	 0 10 20 30 40 50 60 70 80 90 100						
	M.H. Advocates		NA	 0 10 20 30 40 50 60 70 80 90 100						
	Asian C.M.H.S.		NA	 0 10 20 30 40 50 60 70 80 90 100						
	Twin Valley		NA	 0 10 20 30 40 50 60 70 80 90 100						
	Suicide Prevention		NA	 0 10 20 30 40 50 60 70 80 90 100						
	Parental Stress		NA	 0 10 20 30 40 50 60 70 80 90 100						
	Criminal Justice M.H. Unit		NA	 0 10 20 30 40 50 60 70 80 90 100						



we find 59% of mental health programs with half or more of their staff time unallocated to direct or indirect service. While this situation exists, some services have exhibited highly efficient staff utilization - El Centro, Alameda Mental Health Clinic, Central Crisis, Central Rehab, and North Oakland Crisis (W.O.H.C.) to name a few.

3. Ratio of Clinicians to Clients

A clinician to client ratio provides a measure of staff coverage and contact; how many clients are, on average, within the responsibility of a single clinician.

WE CONCLUDE that great variance exists within service modalities regarding the number of clients under the general responsibility of a single clinician.

SUPPORT:

Our analysis indicates that there is little recognizable reason for the large variance in staffing ratios within a given service type. However, the variances are pervasive. To illustrate, averages and ranges (low to high) are provided for each service modality (ratios are rounded to nearest digit).

- a) Crisis/Outpatient Services
Average: 1: 16
Range: from 1: 10 (El Centro) to
1: 24 (Valley Crisis)

- b) Rehab Services
Average: 1: 19
Range: from 1: 7 (Berkeley Rehab) to
1: 31 (Hayward CCSS) and
1: 24 (Tri-City Rehab)



- c) Day Treatment Services
 - Average: 1: 6
 - Range: from 1: 2 (Berkeley Day Treatment)
to 1: 11 (West Oakland Day Treatment)

- d) Children's Services
 - Average: 1: 10
 - Range: from 1: 3 (Lincoln Child Center)
to 1: 17 (Eden Children's Service)

Although a low clinician to client ratio is only an indicator of staff coverage, it does allow one to speculate on the relationship between coverage and impact (see Impact Section).

4. Caseload Comparisons

A comparison of active caseloads is a basic measure of staff activity in direct treatment services.

WE CONCLUDE that, in most cases, active caseloads are reasonably distributed within service modalities and are at levels expected for specific services.

SUPPORT:

Our analysis indicates that the average active caseloads for each major service modality are as follows, with specific services that appear outside the major distribution highlighted:

- a) Crisis/Outpatient Services: 98 average
 - Low: Eden Crisis - 32
 - North Oakland Crisis (W.O.H.C.) - 44
 - High: East Oakland Crisis - 161



- b) Rehab Services: 137 average
Low: Berkeley Rehab - 33
Valley Rehab - 57
High: East Oakland Rehab - 325
- c) Day Treatment Services: 32 average
Low: Berkeley Day Treatment - 17
- d) Children's Services: 70 average
High: Eden Children's Service - 113

Although most services carry the number of active cases that fall close to the average, some services are maintaining a high percentage of open cases that are not active. Specifically, North Oakland Crisis, and Eden Crisis are reporting open caseloads far in excess of the number actually represented in their active workload.



C. General Assessment

1. Patterns

The above analysis and conclusions allow one to arrive at only one conclusion: productivity in Alameda County's county-operated and contracted services is generally low. The poor productivity profile is compounded in some services where measures, when combined, yield a full picture. For example, the following service sites exhibit a high percentage of unallocated staff time and also have above average unit costs:

East Oakland Crisis
Eden Crisis
Eden Rehab

Eden Day Treatment
Probation Guidance Clinic

Of these services, Eden Crisis and Day Treatment also had below average active caseloads.

Although the general productivity picture is bleak, some interesting variations exist:

- Although no general pattern exists when County-operated programs are compared with contract programs, specific County-operated and contract programs surface as productive and cost-efficient services. An examination of Table VI reveals that the following services are generally strong:

a) County-Operated

Alameda Mental Health Clinic
Central Crisis Service
Tri-City Crisis Service
Valley Crisis
Central Rehab Service
East Oakland Rehab
Eden Children's Service

b) Contract

El Centro de Salud Mental
North Oakland Crisis
(W.O.H.C.)
Berkeley Day Treatment



- It is interesting to note that of the services with the very lowest unit costs and least amount of unallocated staff time - Central Rehab and Crisis El Centro, North Oakland Crisis, Berkeley Day Treatment, and Alameda Clinic - the sole integrated service center, Alameda Mental Health Clinic, has the least unallocated time of all services and nearly the lowest unit cost for all crisis, rehab, and children's services.
- Hospital-based services tend to have among the highest amount of unallocated time (notable exceptions: Central Crisis and Rehab) yet, no pattern exists in their unit costs; non-hospital-based services are equally high in unit cost. The setting does not appear to be the critical variable to explain unit cost differences. Thus, although there is a tendency to see high unallocated time in the hospital-based services, no predominant, overwhelming pattern exists.

B. Reasons

The productivity profile that surfaces raises an interesting question: what factor, or accumulation of factors, could account for the generally poor picture?



A number of conditions within many services are contributing to the present situation:

- a) The almost universal need for clear and embraced expectations for achievement by which a staff can assess its performance.
- b) The need for incentives to reach whatever objectives may exist within a service.
- c) The need for genuine performance evaluations - of both service chiefs and clinical staff members.
- d) The need for defined, reasonable and understood caseload and consultation standards by which achievement can be measured within each service.
- e) The need for achievement - oriented training for clinicians and service managers (including the innovative use of group therapy, team clinical work and home visits). NOTE: Services with extensive use of teams, have home visits and group therapy.
- f) The need for peer pressure to encourage productive activity. NOTE: Where individual workloads are visible to peers - such as in Day Treatment Services - a professional incentive exists for staff to attain a degree of productivity that meets the understood expectations of one's peers.

All of the conditions cited above can be distilled into one pervasive need; to create clear expectations for achievement, fostered by central and site managers, by which conscientious, highly trained staff can measure progress toward realistic goals. The present deficiency contributes to low morale, confusion over service direction and intentions, frustration and wasted, diffused energy. The cost of the present system may well be that potential clients do not get reached or served.



D. Recommendations

WE RECOMMEND that the Mental Health Service begin immediately to develop and implement a work standards and measurement program that applies equally to County-operated and contract programs. This program, in order to succeed and be conscientiously followed, must be linked to realistic objectives that are sensitive to the unique characteristics of a program and its clientele. The program must also carry out a "bottoms-up" decision-making process that recognizes the contribution of line workers as well as managers.

WE RECOMMEND that the Mental Health Service begin to seriously investigate the feasibility of applying to most services some alternative treatment approaches that are innovative and cost-efficient. Use of clinical teams, home visiting and increased use of group therapy are possible beginning points.

WE RECOMMEND that the Mental Health Service critically examine the results of the productivity study and immediately begin to reallocate staff among service sites in order to increase the cost-efficiency and productivity of services while equalizing workloads. This should be a major County-wide priority. Relocation decisions should, however, be made with a clear link between staffing and recognized needs.

APPENDIX

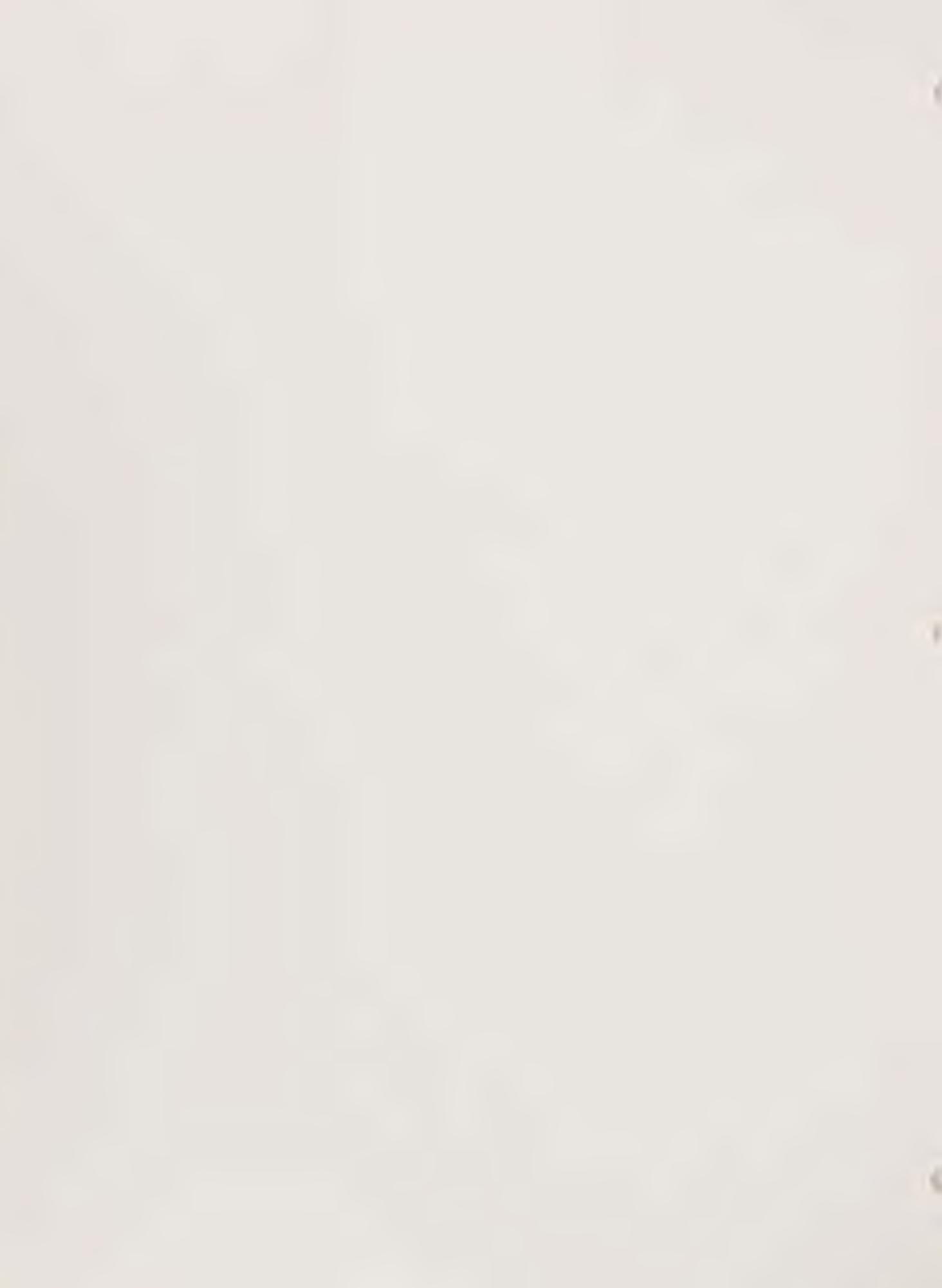
Total number of professional and paraprofessional staff hours available per month.*

Berkeley Crisis		East Oakland Rehab	2,911
Berkeley Rehab	765	E1 Central de Salud Mental	1,768
Berkeley Day Treatment	956	East Oakland Crisis	2,168
West Oakland Day Treatment	680	East Bay Activity Center	340
West Oakland Rehab	1,020	Eden Crisis	319
North Oakland Crisis/ Outpatient	225		
Anne Martin Children's Center	170	Probation Guidance Clinic	1,541
Asian Mental Health		Eden Children Service	1,073
Central Rehab	1,551	Eden Rehab	1,615
Central Day Treatment	1,058	Eden Day Treatment	1,360
Central Child Development	1,233	Fairmont Psychiatric Emergency	
Central Crisis	1,058	Tri-City Crisis	903
Fred Finch Youth Center	680	Tri-City Child Development	659
Fred Finch Day Treatment	276	Valley Child Development	631
Lincoln Child Center	510	Tri-City Rehab	574
Friedman Day Treatment	1,326	Valley Rehab	404
Alameda Mental Health Clinic	1,221	Valley Crisis	733
Highland Psychiatric Emergency		Vocational Rehab	935
East Oakland Health Alliance	1,190		

* Based on total paid hours worked by each staff member (as reported by site to OPE) multiplied by 4.25 to gain a monthly total. Date of data: December, 1975.



MANAGEMENT



MANAGEMENT

Introduction

Mangement is responsible for creating an environment which facilitates the development of a Community Mental Health system that provides effective care for citizens. This is the basic concept which guided our study of mental health management.

We applied the following criteria in our judgment of the capacity of individual managers and administrators throughout the system:

Leadership: in identifying and promoting appropriate organizational objectives.

Coordination: within various levels of operation.

Communication: among relevant persons.

Accomplishments: which promote more effective client care now, or in the future.

Managers depend on certain resources to guide them in making decisions. These are discussed in the following pages in light of their effectiveness and integration within the mental health delivery system. Specifically:

A reporting capacity for communicating decisions and exchanging information.

An evaluation capacity to know how well services are being delivered, and to recognize what changes are needed.

A planning capacity to identify and anticipate what mental health services are needed by how many clients, and where the needs are greatest.

A training capacity to provide staff support and to improve employee performance.

A capacity to respond to community advisory structures.

Our evaluation examines two levels of management:

First, as an overall system which needs to be guided in a consistent direction toward the objective of providing community mental health services.

Second, as a series of line activities carried out by Service Chiefs in coordinating their respective programs.

Reflecting these levels, the Management evaluation is presented in three parts:

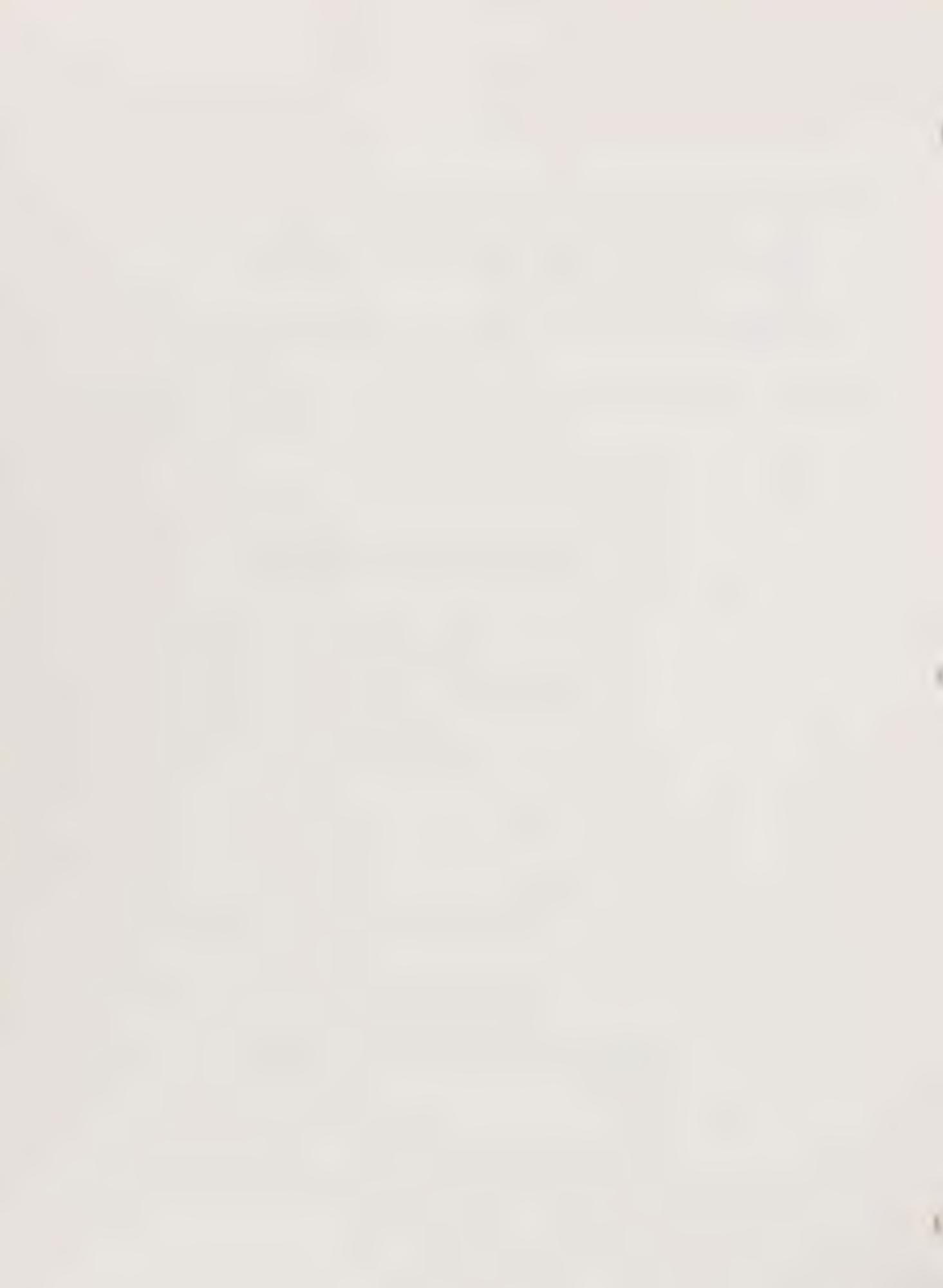
PART I. The Management Environment

PART II. The Management System

- A. Summary of Conclusions and Recommendations
- B. Reporting Capacity
 - 1. Communication Among County Mental Health Programs
 - 2. Communication Between Mental Health Contractors and the County
 - 3. Contract Selection, Monitoring, and Renewal
- C. Evaluation Capacity
- D. Planning Capacity
- E. Training Capacity
- F. A Capacity to Respond to Community Advisory Structures

PART III. The Service Chief as Manager

- A. Summary of Conclusions and Recommendations
- B. Leadership
- C. Morale
- D. Program Procedures
- E. Supervision
- F. Program Analysis



PART I

The Management Environment

Many mental health programs have been created within Alameda County in a relatively short period of time.* This has created diversity in interests and values among both County-operated and contract services. Administrators face problems of coordination with other mental health services, and with other public and private agencies serving the same clientele.

The new Local Mental Health Director faces these management issues while making key staffing changes, and redefining job responsibilities. Program policies are being changed, and County services are being re-organized. In short, Mental Health is in a period of transition.

These changes follow a series of previous administrative reorganizations. It was only in 1973 that all mental health services were arranged by district areas, with responsibilities (at least in theory) being delegated to District Mental Health Officers. Now these districts are being phased into a North and South regional structure. Throughout our evaluation, employees have clearly conveyed their confusion and job-related anxieties in the midst of constant change. This report may reflect, most of all, the cost of too much organizational change.

The fundamental issue facing mental health management is the development of a Community Mental Health system in Alameda County that is cost effective.

* The Community Mental Health system was mandated by State law (Short Doyle Act) in 1957, and County services were expanded with matching State funds (90%) and County funds (10%) beginning in 1970. Along with this expansion came the mandate to implement new programs to reduce use of State hospitals.



Recently, the State has threatened to penalize Alameda County for "over-utilizing" Napa State hospital by decreasing its Short Doyle funds. This forces the Local Mental Health Director to make inpatient treatment a top priority.

During our evaluation, the new Mental Health Director has shown remarkable leadership in beginning to improve the delivery of service and promoting coordination among units of the mental health system. For example:

- A new County Subacute facility is being planned to reduce the use of inpatient services. It was designed after a review of the County's admission and discharge system for Napa State Hospital patients. Another study of inpatients in Highland Hospital is underway now.
- A County-wide resource allocation workshop was held, and committees are helping develop a technical planning capacity.
- Special attention is being given to improve the County's charges and financial reporting system for Mental Health programs.
- A new employee performance evaluation procedure is underway to improve personnel supervision.
- A County-side referral confirmation system is being implemented to improve continuity of care.
- The Mental Health Director is taking the initiative in coordinating intra-agency program plans for clients who have combined mental health and drug, or alcohol problems.
- And finally, the Director enjoys (and deserves) the reputation of being accessible and responsive to community advisory groups, to mental health providers, and to her administrative staff. Dr. Mandel has responded quickly to our evaluation team's requests for information, and is a regular participant on our Ad Hoc Advisory Committee for this evalution.



Our study recognizes the transitional stage of Mental Health's management system. We offer here positive recommendations on issues which have, systemically (or historically) caused management difficulties.

g PART II

THE MANAGEMENT SYSTEM

Summary of Conclusions and Recommendations

Reporting Capacity

Evaluation Capacity

Planning Capacity

Training Capacity

Responsiveness

Summary of Conclusions and Recommendations
on the Management System

Reporting Capacity

Communication Among County Mental Health Programs:

WE CONCLUDE that communication is poor between County Service Chiefs and the Local Mental Health Director, and Regional Directors, partly because of ambiguous lines of District-level authority.

WE RECOMMEND that job responsibilities and authority be clarified between the Regional Directors and former District Mental Health officers.

WE CONCLUDE that Services Chiefs of Contract programs have more direct access to the Regional Director and Mental Health Director than do County Service Chiefs.

WE RECOMMEND contractors and County Service Chiefs have equal access to the Director or Regional Directors.

WE CONCLUDE that County programs in East Oakland's NIMH-funded area, are suffering from lack of coordination and administrative support.

WE RECOMMEND that the local Mental Health Director and North Regional Director assign authority and responsibility to coordinate and provide sustained technical assistance to East Oakland mental health programs, especially the Rehabilitation and Crisis services.

Communication Between Mental Health Contractors and the County

WE CONCLUDE that communication with contractors and the County Mental Health Administration is weak.

WE RECOMMEND that responsibility for liaison with contract programs be re-examined by the Local Mental Health Director and the North Regional Director, and that appropriate steps be taken in response to conclusions and recommendations that follow in this report.

WE CONCLUDE that communication between the County and mental health contractors is weak, in part, because of the County's ill-defined organization, both within mental health and in other County offices that have financial, legal, or reporting links with contractors.

WE RECOMMEND that the North Regional Director and the Contracts' Officer, with assistance from the County Administrative Office, provide some form of orientation to the County's organizational structure for new contractors. This may be in the form of a workshop, a directory, or a procedures manual that identifies contractors' responsibilities vis-a-vis County routines that are not explicitly defined in their contracts. This should include identification of time-lines or critical deadlines for payment forms; and identification by name, job title, phone number and address of the key County offices with which they must confer. This directory should include relevant County offices beyond Mental Health's staff.

Contract Selection, Monitoring, and Renewal:

WE CONCLUDE that authority and responsibility for Short-Doyle contract performance monitoring and program review (in terms of quality of care, client satisfaction, effectiveness of treatment, and cost per unit client satisfaction, effectiveness of treatment, and cost per unit of service) are not effectively identified and assigned to provide sufficient information for contract renewal decisions.

WE FURTHER CONCLUDE that contracts do not specify performance standards and program objectives by which contractors' accomplishments can be measured.

WE RECOMMEND that responsibility for Short Doyle contract administration, monitoring, and evaluation be integrated more effectively with the Program Evaluation Unit, the Contracts' Officer, and the North Regional Director or Local Mental Health Director to enable fuller consideration of contract renewal decisions.

WE CONCLUDE that the selection of Revenue Sharing contract programs is not well coordinated with County Mental Health. This, in turn, weakens the chance to develop an integrated system of mental health care.

WE RECOMMEND that the Planning Director of Mental Health, through the office of the Local Mental Health Director, be an integral member of the Revenue Sharing contract selection committee for mental health proposals.

WE CONCLUDE that some contractors have been selected who do not have sufficient expertise in management to provide effective programs. This, in turn, impairs the delivery of mental health services.

WE RECOMMEND that contractors and their proposals be evaluated not only for the programmatic content of the desired service, but for their management capacity as well.

Evaluation Capacity

WE CONCLUDE that responsibility for evaluating cost and effectiveness of County mental health programs has not been clearly identified and assigned. Neither the Mental Health Program Evaluation Unit, nor the contract review staff has as an explicit objective, the conduct of rigorous program evaluation.

WE RECOMMEND that the Local Mental Health Director identify who should have ongoing responsibility for program evaluation and assign the necessary authority. Evaluations performed should examine County and contract mental health programs.

WE FURTHER RECOMMEND that personnel arrangements be made to provide the necessary clinical expertise for qualitative program review within County as well as contractor-provided mental health programs.

WE CONCLUDE that mental health contractors must submit to numerous evaluations, sometimes as many as five in one year; and that duplicate evaluations may unnecessarily divert staff time away from essential program functions.

WE RECOMMEND that the Local Mental Health Director's Office, the Office of Program Evaluation, and the County Administrative Office coordinate County evaluation of contracted mental health programs. Further, we encourage cooperative evaluations by the County and private agencies which share responsibility for commonly funded mental health programs, at the very least, by conferring on the scheduling of evaluations.

WE COMMEND the recent special inpatient studies done by the Program Evaluation Unit, and the Resource Allocation Workshop effort.

WE COMMEND the initiative of the Contracts Office and Program Review staff in developing a pilot evaluation tool for both management and program quality studies in contract programs.

Planning Capacity

WE CONCLUDE that the Alameda County Mental Health Plan for 1975 is not an operational plan for developing mental health services in the County according to identified community needs and priorities.

WE RECOMMEND that a comprehensive needs assessment be completed Countywide.

WE FURTHER RECOMMEND that the next Plan develop priorities among Community Mental Health Programs and relate them to identified needs.

WE COMMEND the Local Mental Health Director, the staff members of the Planning Office and the Program Evaluation Unit for their initial Resource Allocation Workshop. We encourage the development of this kind of planning technique.

Training Capacity

WE CONCLUDE that training activities do not (and cannot) systematically contribute to the development of a Countywide Community Mental Health system because there is no overall program design or set of priorities available to guide choices among competing County programs' training requests.

WE RECOMMEND closer coordination between the Planning and Training Offices to develop a Community Mental Health design with training appropriately emphasized and integrated.

WE CONCLUDE that the division between training regions in the North and South impairs effective modality training, and hinders the sharing of training resources.

WE RECOMMEND that staff changes be made, if necessary, to improve the cooperative use of training resources.

WE CONCLUDE that the training library has lost hundreds of books because of inadequate record-keeping procedures, and that the remaining books are now inaccessible.

WE RECOMMEND that the Regional Directors assign responsibility to explore alternative library resources, perhaps the Medical Libraries in Highland and Fairmont Hospitals, or the County Library system, so that the remaining books are available to County health personnel through an established librarian, with loan privileges extending to both regions.

WE CONCLUDE that clinical training, organized through District Training Committees, does not provide an efficient and effective allocation of training resources.

WE RECOMMEND that clinical training decisions be more centralized, perhaps with modality coordinators as functional consultants to Training Officers.

WE RECOMMEND that some training activities be provided for similar modalities throughout the County. In this way, innovative techniques can be exchanged by different staffs who have similar clients.

WE FURTHER RECOMMEND that priorities for training be developed to target training resources to programs with great need, regardless of their geographic location.

WE CONCLUDE that training activities, as selected by District Training Committees, are not responsive enough to the needs of paraprofessionals.

WE CONCLUDE that Service Chiefs and supervisors are not sufficiently involved in the training choices made by Committees.

WE RECOMMEND that Training Officers, with consultation from paraprofessionals and Service Chiefs, develop training for paraprofessionals working with emotionally disturbed clients in Rehabilitation Services, especially.

WE FURTHER CONCLUDE that special attention needs to be given to training clerical personnel in reception skills and in information and referral service.

WE CONCLUDE that training activities are often announced too late for full participation by interest participants.

WE RECOMMEND that training topics be announced at least two weeks in advance, and earlier if possible, to permit necessary program arrangements and approval by employees' supervisors.

WE CONCLUDE that training in management skills is needed by Mental Health Service Chiefs.

WE RECOMMEND that management funds be used, and workshops be designed, to promote management skills for Service Chiefs.

WE CONCLUDE that mental health employees are not sufficiently familiar with the organization of services through the Health Care Agency and other programs which involve interagency linkages throughout the County.

WE RECOMMEND orientation training sessions especially for new employees, and other employees when possible and appropriate.

WE CONCLUDE that clerical personnel need training in billing and liability procedures (UMDAP).

WE RECOMMEND that UMDAP training be expanded.

WE CONCLUDE that responsibility for placement of students is not clearly established.

WE RECOMMEND that necessary staff changes and assignment of responsibilities be made to ensure adequate placement of nurses, interns, psychologists, and social workers who are training within County programs.

WE FURTHER RECOMMEND that routine, systematic appraisals of training placements be made.

Also, we recommend that decisions to place trainees be based on the overall clinic staff's ability to provide effective support, supervision, and a positive training opportunity, as determined by placement officers' evaluations, and not based on past traditions of "having training students."

WE COMMEND the Southern Region Training Officer for her efforts to improve coordination and employee participation in training events.

Responsiveness

WE CONCLUDE that the purposes and roles of advisory committee members are not well understood by the Mental Health administrative staff, or by the community participants.

WE RECOMMEND that District Committees' roles and appropriate responsibilities be clarified by the members of the Board of Supervisors.

WE FURTHER RECOMMEND that these responsibilities be mutually agreed upon by Advisory Committee members, the Mental Health Director and the Regional Directors.



WE CONCLUDE that communication through the District Committees in the North Region is not working well.

WE RECOMMEND that the Mental Health Director, and/or the Northern Regional Director, and the two Central Committees' membership meet to reconcile their differences.

WE CONCLUDE that the East Oakland Community Board and the Office of Community Liaison and Planning need to clarify their roles and objectives with the County Mental Health Administration.

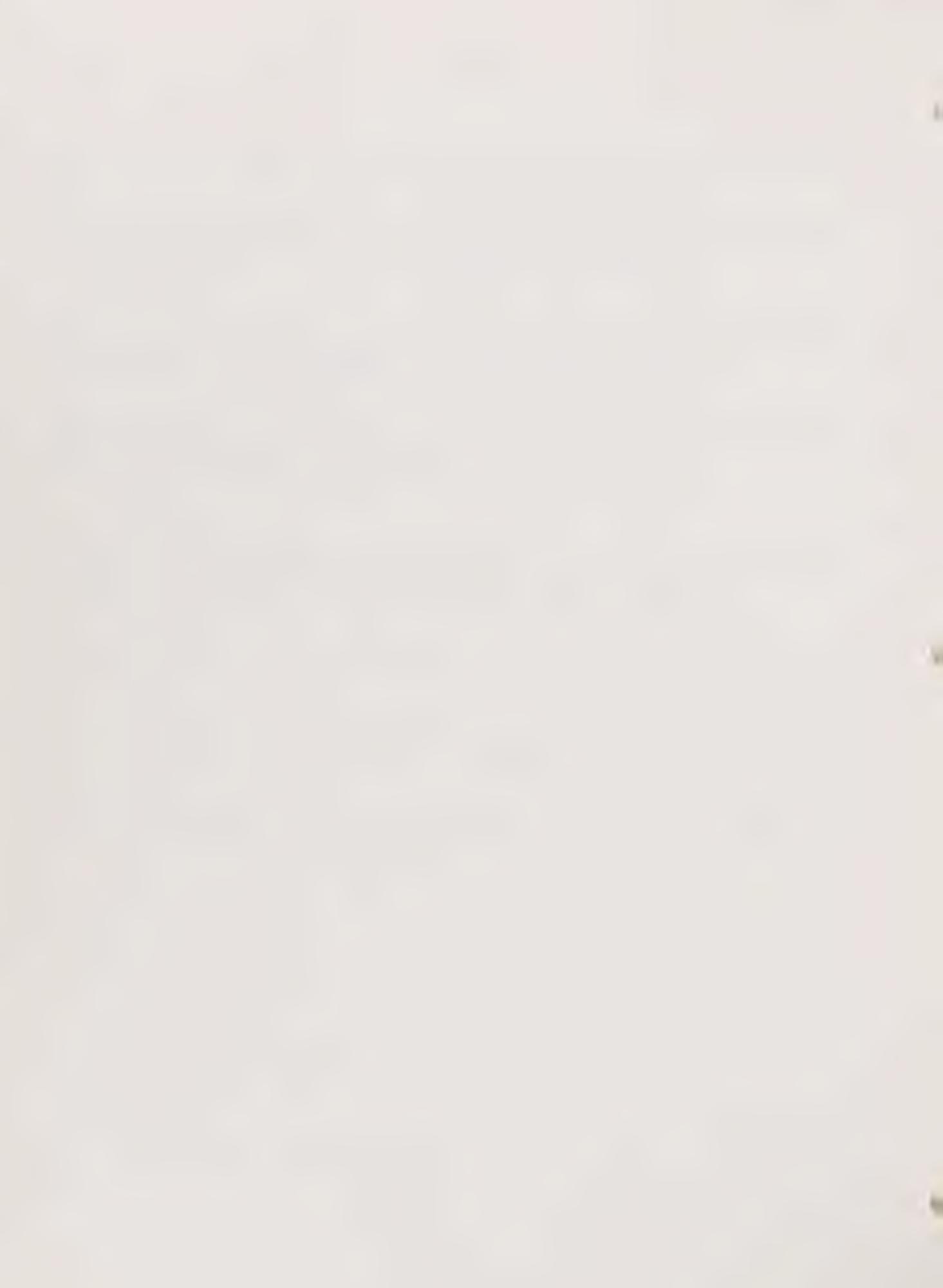
WE RECOMMEND that a re-examination of the Office of Community Liaison and Planning's responsibilities by the staff and the Northern Regional Director with a view to improving communication and coordination among mental health services in East Oakland.

WE COMMEND the Concept of an Annual Report from advisory committees, such as East Oakland Community Mental Health Board's 1975 Report, and we suggest other District Committees consider providing such a document to the interested public.

WE COMMEND the participation of advisory committee people in the Resource Allocation Workshop.

WE COMMEND the commitment and energy spent by citizens out of concern for better mental health services.

WE COMMEND the local Mental Health Director and South Regional Director for their accessibility and responsiveness.



REPORTING CAPACITY

Reporting capacity is the ability to communicate decisions, to exchange information, and to create an environment for continuous feedback. Communication among County mental health programs, and between mental health contractors and the County is examined in this section.

Communication Among County Mental Health Programs

WE CONCLUDE that communication is poor between County Service Chiefs and the Local Mental Health Director and Regional Directors partly because of ambiguous line's of District-level authority.

WE RECOMMEND that job responsibilities and authority be clarified between the Regional Directors and former District Mental Health Officers.

WE CONLCUDE that Service Chiefs of Contract programs have more direct access to the Regional Director and Mental Health Director than do County Service Chiefs.

WE RECOMMEND that contractors and County Service Chiefs have parallel access to the Director or Regional Director.

FINDINGS AND SUPPORT:

In general, we find that communication between Service Chiefs and the Directors is confused by the former District Mental Health Officers' roles. This is particularly troublesome to County Service Chiefs who find an extra layer of authority between them and the Directors, while contract Service Chiefs have easier access to top level decision makers.

Our findings are confirmed through interviews and questionnaire responses. When asked "Who has primary responsibility for supplying Service Chiefs with information about anticipated policy decisions in the County?"



- County Service Chiefs answered as follows:

District Mental Health Officer	(47%)
Regional Director	(37%)
Local Mental Health Director	(16%)

- Contract Service Chiefs answered:

Unclear who holds this responsibility	(29%)
Local Mental Health Director	(24%)
Regional Director	(12%)
District Mental Health Officer	(6%)
My Own Responsibility	(6%)
County Administrative Office	(6%)
Other	(18%)

When County Service Chiefs were asked to identify who is responsible for completing a performance evaluation for them, 26 percent (5 respondents) said it is not clear who holds this responsibility; 37 percent said the Acting Regional Director is responsible; and 5 percent (1) said some "other" person. Interviews with individual Service Chiefs in County programs support these conclusions. Without clearly identified job responsibilities and accountability, effective communication and leadership are impaired.

WE CONCLUDE that County programs in East Oakland's NIMH-funded area, are suffering from a lack of coordination and support.

WE RECOMMEND that the local Mental Health Director and North Regional Director assign authority and responsibility to coordinate and provide sustained technical assistance to East Oakland mental health programs, especially the Rehabilitation and Crisis services.

FINDINGS AND SUPPORT:

We find through our site evaluations that communication and administrative support are weak in the East Oakland programs, especially for the County Crisis and Rehabilitation services. East Oakland Rehabilitation

Service has had supervisory positions vacant for months. This is particularly critical because it is the largest Rehab staff and it depends heavily upon paraprofessional services. (Please refer to East Oakland Clinic Site Evaluations for further details.) This is the area funded by a substantial NIMH grant which, under terms of the grant, calls for a Community Mental Health Coordinator. Judging from the status of East Oakland County programs, there is evidence that special attention is needed.

Communication Between Mental Health Contractors and the County

WE CONCLUDE that communication between contractors and the County Mental Health Administration is weak.

WE RECOMMEND that responsibility for liaison with contract programs be re-examined by the Local Mental Health Director and the North Regional Director, and that appropriate steps be taken in response to conclusions and recommendations that follow in this report.

FINDINGS AND SUPPORT:

We find that communication between contractors and the County Mental Health Administration is weak. Twelve contractors, in a letter dated July 29, 1975, identified issues of common concern including a statement that the power structure and lines of communication were confused, especially with the regional reorganization of County Mental Health Administration. One contract Service Chief said contractors recognize they must maintain their own liaison with the County. This Chief had not heard from the Regional Director in four months (May - September).

Meetings are not regularly scheduled for contractors to meet with the Mental Health Administration. This was confirmed by interviews with individual contract Service Chiefs and Mental Health Administration.

WE CONCLUDE that communication between the County and mental health contractors is weak, in part, because of the County's ill-defined organization, both within mental health and in other County offices that have financial, legal, or reporting links with contractors.

WE RECOMMEND that the North Regional Director and the Contracts' Officer, with assistance from the County Administrative Office, provide some form of orientation to the County's organizational structure for new contractors. This may be in the form of a workshop, a directory, or a procedures manual that identifies contractors' responsibilities vis-a-vis County routines that are not explicitly defined in their contracts. This should include identification of time-lines or critical deadlines for payment forms; and identification by name, job title, phone number and address of the key County offices with which they must confer. This directory should include relevant County offices beyond Mental Health.

FINDINGS AND SUPPORT:

Contractors, in interviews during our overview and site visits, complained about difficulties in identifying appropriate County officials who could complete necessary County Administrative tasks which were essential to the contractors' operations. In particular, there is confusion about the routing of payment forms. This is confirmed by the Health Care Services Agency Administrative Services Study, completed in November, 1975.

Contract Selection, Monitoring, and Renewal

WE CONCLUDE that authority and responsibility for Short-Doyle contract performance monitoring and program review (in terms of quality of care, client satisfaction, effectiveness of treatment, and cost per unit of service) are not effectively identified and assigned to provide sufficient information for contract renewal decisions.

WE FURTHER CONCLUDE that contracts do not specify performance standards and program objectives by which contractors' accomplishments can be measured.

WE RECOMMEND that responsibility for Short Doyle contract administration, monitoring, and evaluation be integrated more effectively with the Program Evaluation Unit, the Contracts' Officer, and the North Regional Director or Local Mental Health Director to enable fuller consideration of contract renewal decisions.

After reviewing mental health contracts, and interviewing the Contracts' Officer and other Central Administrative mental health staff members, we find there is not sufficient information available to make effective contract renewal decisions. The Contracts' Officer, who is highly regarded by contractors and County personnel as being helpful and competent in his duties, has neither the mandate nor staff capacity to monitor programs' quality as therapeutic effectiveness, or client satisfaction in mental health contract operations. A fiscal and management audit is done routinely. Other than this, there is not much basis upon which to negotiate or change Short Doyle contracts.

WE CONCLUDE that the selection of Revenue Sharing contract programs is not well coordinated with County Mental Health. This, in turn, weakens the chance to develop an integrated system of mental health care.

WE RECOMMEND that the Planning Director of Mental Health, through the office of the Local Mental Health Director, be an integral member of the Revenue Sharing contract selection committee for mental health proposals.



FINDINGS AND SUPPORT:

Revenue Sharing contractors are selected independently by the Board of Supervisors, without careful and routine consultation between the local Mental Health Director's office and the County Administrative Office's Revenue Sharing Review Committee. Problems in planning and allocating mental health services subsequently occur. The Health Care Services Agency Administrative Services Study confirms this finding.

WE CONCLUDE that some contractors have been selected who do not have sufficient expertise in management to provide effective programs. This, in turn, impairs the delivery of mental health services.

WE RECOMMEND that contractors and their proposals be evaluated not only for the programmatic content of the desired service, but for their management capacity as well.

FINDINGS AND SUPPORT:

Based on interviews, site visits, and correspondence from the Auditor's office, we find that some new contractors are selected on the basis of their proposed treatment ideas, with insufficient consideration given to their internal management capacity. Start-up costs are often underestimated, and new contractors are reluctant to spend funds for basic management expertise, such as hiring an experienced bookkeeper to set-up the organization's records.

EVALUATION CAPACITY

Evaluation capacity is defined as the ability to know how well services are being delivered, at what cost, and with what impact. Evaluations should identify the changes needed to improve service delivery. The Short Doyle Act states that the County shall include provisions for evaluating mental health services in the county. "After July 1, 1970, program evaluation shall include studies of relative cost and effectiveness of alternative comparable forms and patterns of services."*

WE CONCLUDE that responsibility for evaluating cost and effectiveness of County mental health programs has not been clearly identified and assigned. Neither the Mental Health Program Evaluation Unit, nor the contract review staff has as an explicit objective, the conduct of rigorous program evaluation.

WE RECOMMEND that the Local Mental Health Director identify who should have ongoing responsibility for program evaluation and assign the necessary authority. Evaluations performed should examine County and contract mental health programs.

WE FURTHER RECOMMEND that personnel arrangements be made to provide the necessary clinical expertise for qualitative program review within County as well as contractor-provided mental health programs.

WE CONCLUDE that mental health contractors must submit to numerous evaluations, sometimes as many as five in one year; and that duplicate evaluations may unnecessarily divert staff time away from other essential program functions.

WE RECOMMEND that the Local Mental Health Director's Office, the Office of Program Evaluation, and the County Administrative Office coordinate County evaluation of contracted mental health programs. Further, we encourage cooperative evaluations by the County and private agencies which share responsibility for commonly funded mental health programs, at the very least, by conferring on the scheduling of evaluations.

* Welfare and Institutions Code, Division 5. Community Mental Health Services. Part 2. The Short-Doyle Act, Chapter 2, Section 5658.



WE COMMEND the recent special inpatient studies done by the Program Evaluation Unit, and the Resource Allocation Workshop effort.

WE COMMEND the initiative of the Contracts Office and Program Review staff in developing a pilot evaluation tool for both management and program quality studies in contract programs.

FINDINGS AND SUPPORT:

The Program Evaluation Unit has, historically, collected biostatistics to comply with State reporting requirements for Short Doyle funding. Biostatistics (and discharge report forms) provide information on units of admission, service activity, and discharge, plus some demographic characteristics of past clients (e.g., age, sex, race). These data are, however, not used to analyze programs or to assess program effectiveness or design.

The 1970 mandate from the State to study relative costs and effectiveness of mental health services has not been followed in Alameda County. This has left the County in a poor position to make funding decisions for different programs.

An attempt was made through the Mental Health Contract Review staff and Contracts Office to develop a pilot evaluation for contractors. It was administered in one program. In our opinion, the authority and staff perserverance needed to implement such program review is not currently available, and responsibility has not been clearly identified for such a demanding process. There has not been enough administrative support given to program evaluation in the past. County programs, especially, have not

been examined or compared for standards of quality, cost, or treatment effectiveness. Our efforts, through the Office of Program Evaluation, were the first attempts to provide such comparative information on all County-funded mental health programs.

The new Mental Health Director has taken initial steps to develop the role of the Program Evaluation Unit. Within the last year, special studies of inpatients in Napa and Highland Hospitals have been undertaken. A resource allocation model was started by a staff person from the Planning Office, with consultation and statistical information supplied by the Program Evaluation Unit. We encourage this beginning effort; and we find that through these projects, the Unit's professional expertise is just beginning to be understood and appreciated by County staff.

It remains to be seen, however, if rigorous evaluation is performed throughout the programs. To accomplish this, the capabilities of the Contracts Office, the Contract Review staff, and the Program Evaluation Unit must be integrated. Until this happens, limited and special studies will probably substitute for evaluation.

Finally, we find that some contractors with multiple-funding sources have to respond to as many as five or six evaluations in a year. One mental health program was studied by a Revenue Sharing Evaluation team, Bradwell's Report on Family Supportive Service, the Office of Program Evaluation's Information and Referral team, this Mental Health Evaluation

team, and, no doubt, audited for the Mental Health Contracts Office. While each of these studies is useful to a particular funding source, we can understand the contractors' concern for the programs time involved in responding to each of these studies.

We recommend that all County evaluations of contracted mental health programs be coordinated through the Local Mental Health Director's Office, the Office of Program Evaluation, and the County Administrator's Office. In order to reduce the duplication of staff time and effort, we encourage cooperative evaluations by the County and private agencies which share responsibility for commonly funded programs, at the very least, by conferring on the scheduling of evaluations.

PLANNING CAPACITY

Planning capacity is defined as the ability to identify and anticipate what mental health services are needed by how many clients, and where mental health services are most greatly needed. This assumes needs are systematically identified and placed into a priority system to accomplish the objectives of a community mental health system.

WE CONCLUDE that the Alameda County Mental Health Plan for 1975 is not an operational plan for developing mental health services in the County according to identified community needs and priorities.

WE RECOMMEND that a comprehensive needs assessment be completed Countywide.

WE FURTHER RECOMMEND that the next Plan develop priorities among Community Mental Health programs and relate them to identified needs.

WE COMMEND the Local Mental Health Director, the staff members of the Planning Office and the Program Evaluation Unit for their initial Resource Allocation Workshop. We encourage the development of this kind of planning technique.

FINDINGS AND SUPPORT:

During the time of our evaluation, two out of three of the staff positions (including the Director) in the Mental Health Planning Office were vacant, pending selection and appointment by the local Mental Health Director. For this reason, the formal Alameda County Mental Health Plan for 1975 received emphasis in our review.

The County Mental Health Plan is more a descriptive catalogue of available services, than a plan. It is fragmented, probably because program descriptions were written by various people in different districts

It offered no reconciliation of competing programmatic needs between North and South County between adult and children's services, or between direct and preventive services. It offered no guidance for future resource allocation choices, or for the deployment of current programs. Because a comprehensive needs' assessment was not done, priorities of need could not be identified in relationship to one another. The Plan was complied primarily to meet the State requirement for an annual document from the County.

A more promising effort by the Planning staff in 1975, was the development of an initial Resource Allocation Model. A County-wide Workshop was held, and mental health providers, both contractors and County staff, met with administrative staff and community representatives, to begin developing guidelines for allocating funds within Mental Health Services. We commend this effort, and encourage sustained staff support in this area.

TRAINING CAPACITY

The Mental Health Administration provides four kinds of training for County employees:

1. Administrative training to improve management or clerical performance.
2. Service-oriented training for mental health personnel, to improve or broaden clinical skills.
3. Student training to provide early work experiences under supervision.
4. Continuing education to update professional or career skills. (This is usually accomplished through professional leave benefits or approved leave on County time).

Specific suggestions for these training areas, as well as a review of the training offices' organization, are offered in the following discussion.

Organization of Training

WE CONCLUDE that training activities do not (and cannot) systematically contribute to the development of a Countywide Community Mental Health system because there is no overall program design or set of priorities available to guide choices among competing County programs' training requests.

WE RECOMMEND that closer coordination begin between the planning and training Offices to develop a Community Mental Health design with training appropriately emphasized and integrated.

WE CONCLUDE that the division between training regions in the North and South impairs effective modality training, and hinders the sharing of training resources.

WE RECOMMEND that staff changes be made, if necessary, to improve the cooperative use of training resources.



WE CONCLUDE that the training library has lost hundreds of books because of inadequate record-keeping procedures, and that the remaining books are now inaccessible.

WE RECOMMEND that the Regional Directors assign responsibility to explore alternative library resources, perhaps the Medical Libraries in Highland and Fairmont Hospitals, or the County Library system, so that the remaining books are available to County health personnel through an established librarian, with loan privileges extending to both regions.

FINDINGS AND SUPPORT:

There are two Training Officers for the North and South regions, each with separate budgets. Countywide training sessions are limited because of the split in administrative units. This interferes with an exchange of ideas of staff in the same modality throughout the County, for example, in training sessions for all Crisis Clinics' staff. There is a problem in communication between the two Training Officers and consequently, training equipment and other resources are not shared.

The Training Library in Highland Hospital has suffered from inadequate lending procedures. Approximately 250 books are missing, estimated to be worth between \$5,000 - \$10,000. The remaining books are now locked up and this defeats the purpose of a library.

Without a coherent plan for a Countywide Community Mental Health System, training activities cannot be targeted to clinics' identified priorities of need.



WE CONCLUDE that clinical training, organized through District Training Committees, does not provide an efficient and effective allocation of training resources.

WE RECOMMEND that clinical training decisions be more centralized, perhaps with modality coordinators as functional consultation to Training Officers.

WE RECOMMEND that some training activities be provided for similar modalities throughout the County. In this way, innovative techniques can be exchanged by different staffs who have similar clients.

WE FURTHER RECOMMEND that priorities for training be developed to target training resources to programs with great need, regardless of their geographic location.

WE CONCLUDE that training activities, as selected by District Training Committees, are not responsive enough to the needs of paraprofessionals.

WE CONCLUDE that Service Chiefs and supervisors are not sufficiently involved in the training choices made by Committees.

WE RECOMMEND that Training Officers, with consultation from paraprofessionals and Service Chiefs, develop training for paraprofessionals working with emotionally disturbed clients in Rehabilitation Services, especially.

WE FURTHER CONCLUDE that special attention needs to be given to training clerical personnel in reception skills and in information and referral service.

WE CONCLUDE that training activities are often announced too late for full participation by interest participants.

WE RECOMMEND that training topics be announced at least two weeks in advance, and earlier if possible, to permit necessary program arrangements and approval by employees' supervisors.



FINDINGS AND SUPPORT:

Clinical training is organized along District lines. Each area has a District Committee which is responsible for choosing training activities or work-shops within its allocated portion of funds. There are several functional problems with the District Committee approach to training.

First, membership on the Training Committees tends to reflect the professional clinical hierarchy: paraprofessionals are under-represented. Activities are geared to the interests of those who have had the most professional training, especially in the Southern region. Training needs of clerical personnel are not given consideration by District Committees.

Appropriate reception and referral techniques are critical for clerical personnel. They must be sensitive to clients' requests, and at the same time, know when to transfer a client over to a clinician who is specially trained in intake procedures.

Our site observations and questionnaire responses confirmed the need for clerical reception training. 35 percent of the County clerical respondents, and 44 percent of contract programs' clerical respondents said they would benefit from training in working with emotionally disturbed clients. 47 percent of the County clerks and 48 percent of the contract clerks responding to our questionnaire said they would benefit from training in ways to improve information and referral. Our telephone accessibility study confirmed the need for such training. (See "Accessibility", Quality in Volume II, and Site Evaluations, Volume III, for specific services with reception problems.)



Second, the Service Chief and supervisors who are in a strategic position to know the strengths and weaknesses of their particular staff members are unable to coordinate training for their employees because District Training Committees select the activities. This has most severely influenced staffs with many paraprofessionals, notably rehabilitation services.

Third, since funds are allocated by Districts, there is an assumption that all areas are entitled to about the same amount of training. There is not much chance to target resources to troubled programs. In our site evaluations, we found several services (primarily in the East Oakland area) that need sustained staff support and training. The responsibility to identify and develop priorities of training needs must be clearly assigned. At present, there is no effective leadership to accomplish this.

Because events are scheduled District-by-District, effective sharing and coordination is difficult. Too often, training events are announced so late that interested participants cannot make necessary arrangements to attend.

Communication among similar modalities is fragmented. Some events should be scheduled Countywide for parallel types of service. As we mentioned earlier, Countywide work-shop on crisis intervention for personnel in different crisis clinics could stimulate innovative techniques for different staffs facing similar clients.



In the Southern region, most training activities are focused on clinical topics, with little consideration given to diversifying styles of service for more effective community outreach. This problem may reflect the clinical composition of the training committees.

The Northern region's list of training events reflects more sensitivity to the diversity of its clientele, and the need for tailoring training to the needs of a Community Mental Health system.

Administrative Training

WE CONCLUDE that training in management skills is needed by Mental Health Service Chiefs.

WE RECOMMEND that management funds be used, and workshops be designed, to promote management skills for Service Chiefs.

WE CONCLUDE that mental health employees are not sufficiently familiar with the organization of services through the Health Care Agency and other programs which involve interagency linkages throughout the County.

WE RECOMMEND orientation training sessions especially for new employees, and other employees when possible and appropriate.

WE CONCLUDE that clerical personnel need training in billing and liability procedures (UMDAP).

WE RECOMMEND that UMDAP training be expanded.

FINDINGS AND SUPPORT:

(Management Skills)

Clinicians who are promoted to management positions, find themselves facing different kinds of job demands as a supervisor or Service Chief.



By training, they are more sensitive to recognizing immediate clients' needs, or identifying employees' personal problems; consequently, the operation of the unit, as an organization, may be difficult. This problem is compounded when a clinician, as a Service Chief, has an attitude of scorn or indifference about administrative matters. Organizational problems may accumulate until the delivery of service is damaged; triggered, perhaps, by staff with low morales, who are unhappy with the work environment.

Many Service Chiefs have not had management training. Forty-two percent of the County Service Chiefs and 35 percent of the Contract Service Chiefs said they had not had training for their duties as program managers. Of those who had not had such training, 83 percent of the Contract and 88 percent of the County Service Chiefs said they would consider such training useful. Based on these responses, and solidly confirmed by our site observations, we conclude that training in management skills is needed.

Administrative training can clarify job responsibilities, strengthen organizational skills, and resolve misunderstandings from outdated or ambiguous administrative routines. Without skillful presentation, however, it may be a mechanical presentation of formal procedures and regulations. Judging only from employees' conversations, we conclude that recent employee supervision and performance evaluation sessions were less than successful. In no way do we question the purpose of the training; rather, we suggest that the structure and delivery of training for



an essential management skill like supervision be reconsidered. Supervisors will not be able to appreciate the new employee performance evaluations as a useful management tool until they can relate their own particular working experiences to the concept. Follow-up workshops may be helpful in implementing this valuable supervisory technique.

(Orientation for County Employees)

There is a clear need for an orientation program for mental health employees. This finding is supported by two reports, the Health Care Services Agency Administrative Study, and the Intergovernmental Management Development Institute for Alameda County along with our own conclusion based on interviews and a review of past training activities. Currently, orientation sessions are provided only for training students placed in County programs.

(Training in Billing and UMDAP)

We have found a great variance in billing methods in our study of billing procedures and UMDAP (uniform Method to Determine Ability to Pay. Of the clerical respondents to our questionnaire, 74 percent of the county employees and 52 percent of the contract employees said they would benefit from training in billing. Our investigation confirms this. (See "Effects of Present Billing and Liability Procedures on County-operated and Contracted Mental Health Services" Volume II of this report.)



Student Training

WE CONCLUDE that responsibility for placement of students is not clearly established.

WE RECOMMEND that necessary staff changes and assignment of responsibilities be made to ensure adequate placement of nurses, interns, psychologists, and social workers who are training within County programs.

WE FURTHER RECOMMEND that routine, systematic appraisals of training placement be made.

Also, we recommend that decisions to place trainees be based on the overall clinic staff's ability to provide effective support, supervision, and a positive training opportunity, as determined by placement officers' evaluations, and not based on past traditions of "having training students."

WE COMMEND the Southern Region Training Officer for her efforts to improve coordination and employee participation in training events.

FINDINGS AND SUPPORT:

Student training for apprentice paraprofessionals is arranged through the two training offices.

The responsibility for placement of training students is not clearly established, partly because of staffing vacancies or changes, and partly because leadership is not clearly identified. There are a variety of trainees (nurses, medical interns, social workers and psychologists) and neither officer has full responsibility for placements.

Judging from our site evaluations and interviews, there is no systematic effort to appraise the success of past training placements. Some services with obvious problems in supervision and staff morale are regularly used as training sites.

Based on the summary lists of training events, we find that training events are more effectively organized for students than for County employees. Many of the regularly scheduled trainee events could appropriately include County Employees if supervisors approve time for employees. This arrangement depends on successful advance notice of the training topics. Notably, South region's training officer is circulating invitations to key personnel. We commend her for this effort to improve coordination and broaden training participation.

Continuing Education:

Continuing education to update professional or career skills is individually arranged by County employees through the Service Chief or Regional Director, and guided by Agency regulations.

Our study has not included an evaluation of the regulations. From our questionnaire responses, we find that 70 percent of the County clinical respondents said they are regularly expected to share new knowledge with fellow staff members, while 28 percent said they are not required to do so. Individual programs, quite appropriately, have different methods for sharing new professional information. However, based on our site evaluations, we find that most often this is done through staff meetings or informally. Written reports or specific training sessions are not usually provided by individual clinicians for their colleagues.



RESPONSIVENESS

Our evaluation has looked at the way community advisors contribute to the decisions which affect mental health service.

In general, we find that neither the citizens nor the Mental Health staff agree on effective ways for community participation in mental health program decisions. While the new Mental Health Director is accessible and responsive to community advisors, the participants have not identified and agreed upon mutually helpful roles. Until this happens, frustration will continue to those who attempt this advisory function.

Mental Health Advisory Board

Mental Health Advisory Board members participate conscientiously and contribute effectively when the occasion permits. A diversity of interests is provided by the Board's membership. Its composition, outlined by State guidelines, includes at least 51 percent citizens and non-providers of mental health services. Perhaps because of its State mandate, it is regarded as the primary advisory structure for mental health with district committees reporting to it. Its role is most clearly understood by the concerned parties.

District Advisory Committees

WE CONCLUDE that the purposes and roles of advisory committee members are not well understood by the Mental Health administrative staff, or by the community participants.



WE RECOMMEND that District Committees' roles and appropriate responsibilities be clarified by the members of the board of Supervisors.

WE FURTHER RECOMMEND that these responsibilities be mutually agreed upon by Advisory Committee members, the Mental Health Director and the Regional Directors.

WE CONCLUDE that communication through the District Committees in the North Region is not working well.

WE RECOMMEND that the Mental Health Director, and/or the Northern Regional Director, and the two Central Committees' membership meet to reconcile their differences.

WE CONCLUDE that the East Oakland Community Board and the Office of Community Liaison and Planning need to clarify their roles and objectives with the County Mental Health Administration.

WE RECOMMEND that a re-examination of the Office of Community Liaison and Planning's responsibilities by the staff and the Northern Regional Director with a view to improving communication and coordination among mental health services in East Oakland.

WE COMMEND the Concept of an Annual Report from advisory committees, such as East Oakland Community Mental Health Board's 1975 Report, and we suggest other District Committees consider providing such a document to the interested public.

WE COMMEND the participation of advisory committee people in the Resource Allocation Workshop.

WE COMMEND the commitment and energy spent by citizens out of concern for better mental health services.

WE COMMEND the local Mental Health Director and South Regional Director for their accessibility and responsiveness.

FINDINGS AND SUPPORT:

District level participation is where frustration is most strongly felt, judging from our evaluation interviews. The Board of Supervisors originally established district committees to decentralize planning to the local areas in hopes of developing more responsive services. As the County administration makes the changeover to regions, District Committees find themselves stranded without District Mental Health Officers, and are uncertain about their connection to the County administration. This varies to some extent from district to district, and it is more pronounced in the North region.

Further, we find that, too often, private mental health providers tend to dominate District Committees. This is not to say that they should not participate at all, but rather that membership should include more citizens without professional associations in mental health.

The mental health client, or potential consumer, should be included. If this does not happen, the "advisory" concept deserves to be abandoned, and the role of lobbyist should be recognized on its own terms.

NORTHERN REGION:

Central District

There are two competing Central District Committees, the original Health Care Services Agency group, and the Mental Health District Committee. We recommend that the two Central District Committees meet with the Mental Health Director and North Regional Director to resolve their differences and to identify meaningful areas for advisors' contributions.



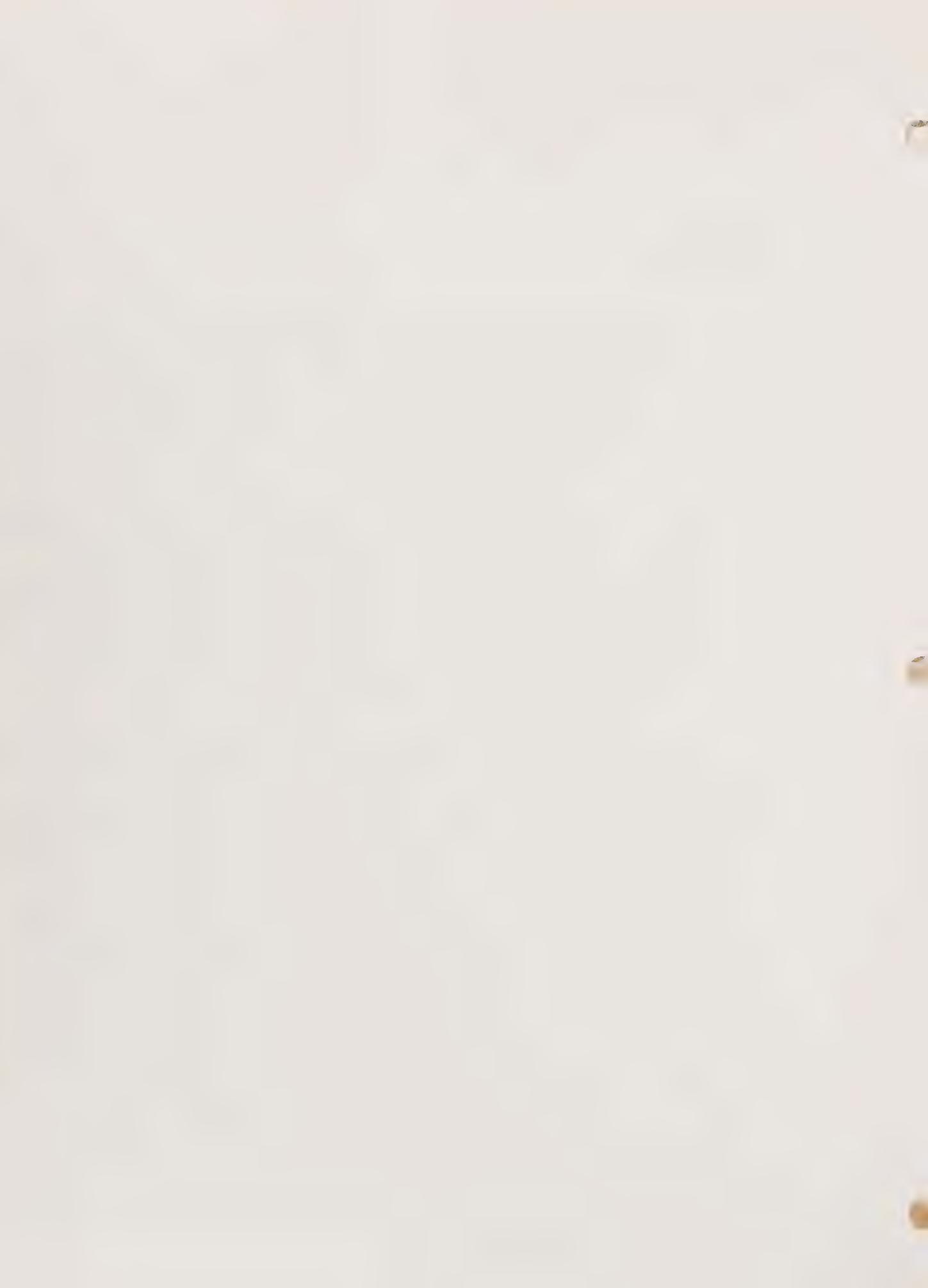
NORTHERN REGION:

East Oakland

The East Oakland Community Board differs from other district committees in that NIMH funds provide it with two County employees as staff. County staff to the Board are known as the Office of East Oakland Community Liaison and Planning (OCLAP).

The Community Board has not been able to mobilize support for the troubled East Oakland County mental health programs, despite their persistent personnel problems in 1975. In its review of this study, the Board agreed with the findings and recommendations in our site evaluations of East Oakland Crisis Clinic and Rehabilitation Service.

There is a question about the effectiveness of communications between the Board, OCLAP, and the mental health programs. Many of the active Board members are private mental health contractors. The Board's by-laws exclude County mental health employees from membership. At the same time, OCLAP has a very limited relationship with mental health program staff. OCLAP attends staff meetings of County programs in East Oakland, but there is not a cooperative interchange of ideas between the liaison staff and clinicians. So far, OCLAP does not attend staff meetings of contractors. OCLAP began an evaluation of East Oakland mental health services in September, 1975, with visits to the clinics. According to the staff, a report will be issued sometime in the future. The liaison staff appear to be alienated from clincial staff, and unable to foster communication within the District's mental health programs.



SOUTHERN REGION:

District groups are combining to meet as one unit with the Southern Regional Director. This seems to provide effective communication at an appropriate level for this area.

Participants represent a diversity of interests in the community. Their commitment and initiative have promoted community support for mental health services in South County.

The Eden area citizens have undertaken a study of the budget and finance systems for Mental Health. Administrative staff support has been provided, but the payoff from this effort can probably be only one of "watchdog," by the advisors. While this is certainly a possible role for them to choose, we wonder if their time might be better contributed to other areas of decision.

One of the best examples of worthwhile participation for all advisory groups, North and South, was the Resource Allocation Workshop sponsored by the Mental Health Director in October, 1975. We commend this kind of forum and see it as an effective way for mental health providers, citizens, and professional planners to meet on common ground.

We respect the commitment and energy spent by District Committee members and recognize that their contributions can be valuable. It remains for them and the County to define their roles for the most impact on Mental Health Services. The Mental Health Director and Regional Directors must confer with advisory committee members in honest dialogue, to identify their roles.



One of the Community Board's current objectives is to explore incorporation. Members believe this would change it from an advisory group to a decision-making body. It would also make any contributions to it tax-deductible.

The East Oakland Community Board's primary contribution, judging from its 1975 Annual Report and from interviews, is advocacy for Third World interests in program and staffing choices within the County's mental health services. The Board, in its response to our study, said it has a good relationship with the North Regional Director.

WE COMMEND the concept of an Annual Report from advisory committees, and suggest other District Committees consider providing such a document to the interested public.

WE CONCLUDE that the East Oakland Community Mental Health Board and the Office of Community Liaison and Planning need to clarify their roles and objectives vis-a-vis programs in East Oakland and the County Mental Health Administration.

WE RECOMMEND a re-examination of OCLAP's responsibilities by the staff and the Northern Regional Director in view of improving communication and coordination among mental health services in East Oakland.

NORTHERN REGION:

Alameda District

Alameda is a sub-district of the East Oakland District. Its meetings are held separately from the East Oakland Community Board. Participants are generally providers of mental health services. We recommend that a broader range of community interests be included in the Alameda District Committee.



PART III

THE SERVICE CHIEF AS MANAGER

Summary of Conclusions and Recommendations

Leadership

Morale

Program Procedures

Supervision

Program Analysis



Part III

THE SERVICE CHIEF AS MANAGER

The following discussion summarizes patterns of concerns which are identified throughout the individual mental health programs in both contract and County-operated clinics. We recognize that many circumstances cannot be "solved" from the Service Chief's position of authority. This distinction is made whenever possible in this section of the report.

Elements of the working environment are highlighted to identify areas which need attention or deserve recognition. Our information sources include questionnaire responses from all clinicians, clerical staff, and Service Chiefs; intensive interviews with the Service Chiefs; interviews with staff; examination of documents and procedural manuals, and observations made in both scheduled visits and unannounced contacts.

Our findings are divided into five sections:

1. Leadership
2. Morale
3. Program Procedures
4. Supervision
5. Program Analysis



Leadership

WE CONCLUDE that clinicians, as managers, may neglect or misunderstand administrative responsibilities.

WE RECOMMEND that the Director and Regional Directors clarify administrative responsibilities for County Service Chiefs. We recommend that training be provided for appropriate management skills.

WE CONCLUDE that authority and responsibility are confused within the County's administrative system, and this, in part, stems from recent staffing changes.

WE RECOMMEND that all County Mental Health administrative officers have clearly defined job responsibilities, and that these administrative assignments be communicated directly to all Service Chiefs, in contract and County programs.

WE CONCLUDE that leadership and coordination are weaker in the North Region.

WE RECOMMEND that responsibility for coordination among contract and County mental health programs be clearly assigned and strengthened by staff changes, if necessary.

WE CONCLUDE that contract Service Chiefs are most often concerned with budget constraints; while County Service Chiefs are often concerned with budgets, Napa Hospital utilization, and personnel changes.

WE FURTHER CONCLUDE that more County Service Chiefs believe that paying for treatment is usually a positive part of therapy than do contract Service chiefs.

WE RECOMMEND that discussions between contract and County-operated Service Chiefs lead to a common understanding of the "payment for therapy" issue, from both treatment and financial perspectives.



Morale

WE CONCLUDE that morale is higher among employees in contract programs.

WE CONCLUDE that staff morale in County programs is suffering from transitional staffing and indecisive leadership during this prolonged period of organizational changes.

WE RECOMMEND that regional job responsibilities be clearly identified and communicate throughout County and contract Mental Health programs. We further recommend that regional assignments be completed as quickly as possible.

WE CONCLUDE that notable differences in staff morale exist among service modalities. Morale is higher among Day Treatment Clinics, and lower among Rehabilitation Services and Crisis Clinics.

WE RECOMMEND that sources of low morale be addressed, and that corrective action be taken for Crisis and Rehab Services.

Specifically, WE RECOMMEND that supervisory positions be filled immediately, and that staff support and training be increased. We further recommend that training be offered among common modalities, including Rehabilitation and Crisis Services.

WE RECOMMEND re-examination of the role of Crisis Clinics by the Regional Directors and the Crisis Service Chiefs with the hope of clarifying program objectives and improving the range of services available.



Program Procedures

WE CONCLUDE that referral procedures, in general, are not effectively organized to ensure continuity of care for clients.

WE RECOMMEND that appraisals of referrals be done systematically to improve information for future referrals.

WE RECOMMEND that County program notify private agencies that adequate discharge planning is expected for clients being referred to County programs. We further recommend that County referrals be made selectively to those agencies which do, in fact, make sufficient preparations to ensure continuity of care for their clients.

WE COMMEND the efforts to implement the new referral confirmation system.

WE CONCLUDE that policies for guiding referrals to the private practices of staff members, including psychologists, psychiatric social workers, and doctors are ambiguous, at best.

WE RECOMMEND that Service Chiefs develop clear safeguards to protect against possible conflicts of interest in referrals to staff members' private practices. This is not to imply that referrals can never be made appropriately to the private practice of staff members.

WE CONCLUDE that current community resource information is not generally available to many program staff members.

WE RECOMMEND that Service Chiefs assign responsibility to staff members to collect and routinely update centrally available community resource information.

WE CONCLUDE that most programs do not have effectively organized program manuals.

WE RECOMMEND that Service Chiefs develop more thorough program manuals, especially for large staffs, so routine program functions are clearly understood, and job responsibilities are clearly identified.

WE COMMEND the Asian Community Mental Health Services and El Centro de Salud Mental for their outstanding program manuals.



Supervision

WE CONCLUDE that supervisory skills and staff support are generally weaker among Service Chiefs who have been trained as clinicians only.

WE RECOMMEND management training in supervisory skills for Service Chiefs and line supervisors.

WE COMMEND the recent efforts to implement a County employee performance evaluation system.

WE CONCLUDE that supervisory positions are sometimes awarded County employees on the basis of seniority, not supervisory skills. This can weaken staff support.

WE RECOMMEND that supervisory skills be considered, first and foremost, in employee promotions to supervisory jobs.

WE CONCLUDE that County personnel procedures impede personnel changes that may improve supervision.

WE RECOMMEND that Regional Directors, when necessary, provide sustained support to Service Chiefs who must accomplish difficult staff changes, especially employee dismissals.

WE CONCLUDE that the County personnel freeze has weakened supervision, especially in Rehabilitation Services.

WE RECOMMEND that supervisory positions be filled immediately in Rehabilitation Services.



Program Analysis

WE CONCLUDE that program analysis needs to be developed in most mental health programs.

WE COMMEND Mental Health Advocates, Parental Stress, and Asian Community Mental Health Services for developing good foundations for program review; along with Tri-City Rehabilitation Service, Central Rehabilitation Service, and Probation Guidance Clinic.

WE RECOMMEND that management training be provided for Service Chiefs to develop program review techniques.

WE RECOMMEND that management support be provided through the Mental Health Planning Office and Program Evaluation Unit for County Programs.

WE RECOMMEND further that Regional Directors consider program review to be a management responsibility of each Service Chief.



LEADERSHIP

Leadership is defined as the ability to organize, communicate, and to coordinate activities; to provide direction and advocacy; to act decisively; to motivate staff; and to address and resolve problems.

WE CONCLUDE that clinicians, as managers, may neglect or misunderstand administrative responsibilities.

WE RECOMMEND that the Director and Regional Directors clarify administrative responsibilities for County Service Chiefs. We recommend that training be provided for appropriate management skills.

FINDINGS AND SUPPORT:

In general, leadership difficulties in mental health programs stem from promoting successful clinicians into management positions. Their clinical training and orientation make them more sensitive to immediate clients' needs, and consequently, they may ignore management difficulties or give them last minute attention. The operational payoff from management techniques such as employee performance evaluations, program monitoring, planning, and review may seem too remote to be worth staff effort and time. This problem is compounded when clinicians, as Service Chiefs, have an attitude of scorn or disdain about administrative matters. Consequently, both the working environment and the capacity to improve service can suffer. This leadership problem is found in both County and contract programs, but judging from our site evaluations, it is most often in County programs.

WE CONCLUDE that authority and responsibility are confused within the County's administrative system, and this, in part, stems from recent staffing changes.



WE RECOMMEND that all County Mental Health administrative officers have clearly defined job responsibilities, and that these administrative assignments be communicated directly to all Service Chiefs, in contract and County programs.

FINDINGS AND SUPPORT:

As expected, communication is more difficult for the Service Chief from the clinic level up through the County system's lines of authority. Remnants of District organization still interfere with coordination and communication. Key administrative positions have been vacant, pending the Mental Health Director's staffing decisions. A Countywide personnel freeze has compounded personnel problems. Individuals are serving as "acting" administrators in this transition period. Serious management problems have developed because of transitional staffing, indecision, and confusions over job responsibilities.

When County Service Chiefs were asked to identify who is responsible for completing a performance evaluation for them, 26 percent (5 respondents) said it is not clear who holds this responsibility; 37 percent said the Acting Regional Director is responsible; and 5 percent (1) said some "other" person is responsible.

When asked who has primary responsibility for supplying Service Chiefs with information about budget decisions, 32 percent of the County Chiefs identified the District Mental Health Officer, 47 percent identified the Regional Director, 11 percent identified the Mental Health Director, and 11 percent (2) said the responsibility is unclear.



When County Service Chiefs were asked who has primary responsibility for supplying them with information about anticipated policy decisions in the County, 47 percent identified the District Mental Health Officer; 37 percent identified the Regional Director; and 16 percent identified the Mental Health Director. We conclude that County Service Chiefs still face confusion over district lines of authority, and have less direct access to the local Mental Health Director than do Contract Service Chiefs.

WE CONCLUDE that leadership and coordination are weaker in the North Region.

WE RECOMMEND that responsibility for coordination among contract and County mental health programs be clearly assigned and strengthened by staff changes, if necessary.

FINDINGS AND SUPPORT:

We traced several significant memos from County employees requesting policy decisions or clarification through Mental Health's administrative chain of command for our management evaluation. We found that although the memos reached the Regional Office for North Region, decisions and appropriate follow-through did not occur.

For example, a District Mental Health Officer requested clarification of County procedures to safeguard against possible conflicts of interest in referrals to County clinicians' private practices. There was little follow-through on this policy issue by the Office of the Northern Region, perhaps because the person who raised the question was leaving County employment. Nevertheless, the need to develop safeguards against possible



conflicts of interest is still very much a management issue which deserves attention by the Mental Health Administration. (See "Program Procedures" following later in this section.)

Another example involves a set of memos detailing client complaints about service in a mental health clinic, sent to the Northern Regional Office. Because the office refused to share information with the Office of Program Evaluation about the memos or the action taken to follow-up the complaints, we do not know what, if any, corrective steps were taken. This refusal, by the way, sharply contrasted to our experiences of general cooperation from other Mental Health administrative staff.

Leadership has suffered, most of all, by delays in reorganizing the North region. While staff in the Southern region have been considering plans for changing their programs since January, so far as we can determine, as of March 1976, no proposal has been developed and circulated for the Northern region. County employees know "changes are to be made" but these changes have not been discussed with staff who are involved. This interferes with Service Chiefs' ability to plan and direct their clinics' operations effectively. This, in turn, weakens staff morale.

Contract Service Chiefs' responses to our questionnaire reflect problems in leadership and coordination in the North Region. When asked "Who has primary responsibility for supplying Service Chiefs with information about anticipated policy decisions in the County?" 29 percent of the contract Chiefs said it is unclear who holds this responsibility; 24 percent

identified the Local Mental Health Director; 12 percent identified the Regional Director; and 6 percent (1) said it was his or her own responsibility.

It is our understanding that the Northern Regional Director officially holds responsibility for communication and coordination with contract programs (all but one are located in the North Region).

Finally, the problems in East Oakland's County programs stemming from a lack of coordination and administrative support seriously weaken leadership in the Northern region.

While the Southern Regional Director is making organizational changes which are not especially popular, his leadership provides a general understanding of job responsibilities, and lines of communication are fairly clear.

WE CONCLUDE that contract Service Chiefs are most often concerned with budget constraints; while County Service Chiefs are often concerned with budgets, Napa Hospital utilization, and personnel changes.

WE FURTHER CONCLUDE that more County Service Chiefs believe that paying for treatment is usually a positive part of therapy than do contract Service Chiefs.

WE RECOMMEND that discussions between contract and County-operated Service Chiefs lead to a common understanding of the "payment for therapy" issue, from both treatment and financial perspectives.

FINDINGS AND SUPPORT:

Striking differences are seen between County and contract Service Chiefs when we compare their questionnaire respondents.



Funding and budget constraints are the greatest concern of Contract Service Chiefs. Ninety-four percent of the contract respondents identified this as their primary management concern. Sixty-three percent of the County Service Chiefs are "often" concerned about budget constraints.

Reducing the number of clients being sent to Napa Hospital is "never" a management problem for 47 percent of the contract Service Chiefs while it is "often" a management difficulty for 47 percent of the County Service Chiefs. In part, this reflects the County's authority to admit clients to Napa Hospital, a responsibility which is not held by mental health contractors. However, it is likely that contractors' staffs, in general, do not appreciate the pressure upon Alameda County to reduce its use of Napa Hospital. The County programs are the last stop for clients before State hospitalization.

There are County employees working hard to support clients in the community and to help them avoid State hospitalization.* This priority is reflected in the County Service Chiefs' answers regarding the policy to reduce Napa hospitalization rates.

* Central Day Treatment, for example, has someone on call 24 hours a day in case clients from its clinic happen to arrive at Highland Psychiatric Emergency Service, the admission point for Napa Hospital from Alameda County. There are emergency contingency plans for each of their clients.



County Service Chiefs are "often" concerned about difficulties in making personnel changes; and are "often" concerned about the limitations of treatment options (47 percent of the respondents). Contract Service Chiefs did not identify these issues as frequent management difficulties. In other words, County Service Chiefs perceive more management constraints than do Contract Service Chiefs.

Finally, more County Service Chiefs (84 percent) believe paying for treatment is usually a positive part of therapy for clients, than do Contract Service Chiefs (69 percent). The implications of this difference in policy about clients paying for treatment deserves further exploration, especially when the reverse side of this issue is considered: 31 percent of the Contract Service Chiefs do not believe paying for treatment is usually a positive part of therapy.

MORALE

Morale is defined as a sense of confidence, enthusiasm, and loyalty shared with others in commitment to the goals of the mental health program.

Our study depends on several data sources. First, we asked each respondent through our questionnaires, to assess their own staff's overall morale, and their individual morale, on a five-point scale (from "Very High" to "Very Low"). Throughout our six months of evaluation, we made informal observations and scheduled visits to each mental health program. Our contacts with various program staffs have provided us with valuable experiences. Morale is a subjective dimension, but one that can be checked against other indicators, such as leadership, responsiveness, and quality of care provided.

WE CONCLUDE that morale is higher among employees in contract programs.

WE CONCLUDE that staff morale in County programs is suffering from transitional staffing and indecisive leadership during this prolonged period of organizational changes.

WE RECOMMEND that regional job responsibilities be clearly identified and communicated throughout County and contract Mental Health programs. We further recommend that regional assignments be completed as quickly as possible.

FINDINGS AND SUPPORT:

County Service Chiefs expressed frustration and bewilderment about the difficulties of getting administrative action on requests which could improve their clinical operations. There are problems, especially, in decisions for personnel action; for location changes of clinics; and



for repairs and maintenance for clinics in County hospitals. Service Chiefs often could not tell us why particular requests had been denied, "lost", or who needed to take further action to complete a decision.

Key supervisory positions in County clinics have been vacant for months, even after the Countywide personnel freeze ended. (See East Oakland site evaluations, Volume III.) Supervision and staff support are weakened with such slow administrative response. Morale drops as a result.

Because County programs were being reorganized during our evaluation, a certain level of staff anxiety is to be expected. However, administrative indecision has continued for months. Even now in May, there is no plan available (to our knowledge) for program changes in the North region. Such prolonged uncertainty weakens staff morale.

It is not surprising to find that morale is higher among contact personnel in our questionnaire results. Here is a comparison of clinicians' self-assessments of staff morale:

Morale is rated:

<u>Contract</u>		<u>County</u>
26%	Very high	8%
43%	High	29%
20%	Fair	30%
8%	Low	25%
3%	Very Low	8%

(107 total respondents)

(203 total respondents)

Contract employees more often rate their own morale as "high" or "very high" while County employees rate theirs significantly lower.

WE CONCLUDE that notable differences in staff morale exist among service modalities. Morale is higher among Day Treatment Clinics, and lower among Rehabilitation Services and Crisis Clinics.

WE RECOMMEND that sources of low morale be addressed, and that corrective action be taken for Crisis and Rehab Services.

Specifically, WE RECOMMEND that supervisory positions be filled immediately, and that staff support and training be increased. We further recommend that training be offered among common modalities, including Rehabilitation and Crisis Services.

WE RECOMMEND re-examination of the role of Crisis Clinics by the Regional Directors and the Crisis Service Chiefs with the hope of clarifying program objectives and improving the range of services available.

FINDINGS AND SUPPORT:

In general, Day treatment staffs enjoy higher morale than other service modalities. Site evaluations confirm this (refer to Volume III for specific ratings among services). This may be a function, in part, of working intensively with the same clients within a given time period, for a clear objective, to avoid hospitalization. Day Treatment is usually a team function, and staff members share experiences and information about the same clients.

Rehabilitation Services are generally lower in staff morale. Again, our site evaluations confirm this finding, and the reader is referred to Volume III for specific morale ratings of individual clinics. Lower staff morale may be understood, in part, by recognizing the severely impaired functioning of some rehabilitation clients. Rehabilitation is a long-term goal, with success being realized in small and limited incremental changes. Realistically, some rehabilitation clients require sustained help just in maintaining their present levels of functioning.



Another factor in low morale is the personnel freeze which has most seriously hit Rehabilitation staff who depend on supervisors' support for the largely paraprofessional staff. Vacant supervisory positions have strained the Service Chiefs, as well as the staff's morale.

Finally, we find that morale among Crisis Clinics varies, but as a modality, staff morale seems lower than some others. Our site evaluations confirm this pattern and the reader is referred to Volume III, for specific clinics' morale ratings. The lower morale in Crisis clinics may, in part, be a function of poorly defined program objectives. Crisis clinics offer services often overlap with emergency and Day Treatment.

Crisis staff members are regularly faced with the dilemma of deciding which clients they should try to serve, and which they should refer to another modality. An on-going therapeutic relationship is not officially permitted by Crisis guidelines. They are expected to be available and responsive to the "crisis" client, and at the same time, to provide limited short-term, but regularly scheduled care. Their ability to respond to crisis, at least in County programs, depends on management decisions which may be beyond their control. These circumstances may create environmental tensions that pose difficulties for Crisis employees.

PROGRAM PROCEDURES

Program procedures are defined as clear routines organized to accomplish necessary activities for ongoing service. We examined office practices, record-keeping, referral policies, client confidentiality safeguards, and the collection of community resource information in each of the mental health service delivery sites.

WE CONCLUDE that referral procedures, in general, are not effectively organized to ensure continuity of care for clients.

WE RECOMMEND that appraisals of referrals be done systematically to improve information for future referrals.

WE RECOMMEND that County programs notify private agencies that adequate discharge planning is expected for clients being referred to County programs. We further recommend that County referrals be made selectively to those agencies which do, in fact, make sufficient preparations to ensure continuity of care for their clients.

WE COMMEND the efforts to implement the new referral confirmation system.

FINDINGS AND SUPPORT:

In general, we find that referral procedures need attention in both County and contract programs.

First, appraisals of referrals are not done by many programs on a systematic basis. While a new referral confirmation system is being started throughout the County, it only confirms the initial appointment with the receiving mental health provider. To improve future referrals, individual program staff members must assess the appropriateness and success of their



referrals. Our site evaluations (Volume III), present specific information on the referral assessment practices of individual programs. However, Eden Children's Service and Central Day Treatment deserve special mention for their initiative in appraising public and private sector referrals.

Second, County programs are in a good position to request improvements in discharge planning by private providers sending clients to County facilities. Future referrals from the County to these providers should depend upon the County's assessment of their treatment and discharge planning. County referrals should be made selectively to providers who do make adequate arrangements for their clients' discharge. The Southern Regional Director deserves credit for encouraging private providers to improve continuity of care for clients with this approach.

WE CONCLUDE that policies for guiding referrals to the private practices of staff members, including psychologists, psychiatric social workers, and doctors are ambiguous, at best.

WE RECOMMEND that Service Chiefs develop clear safeguards to protect against possible conflicts of interest in referrals to staff members' private practices. This is not to imply that referrals can never be made appropriately to the private practice of staff members.

FINDINGS AND SUPPORT:

Our questionnaire asked clinicians "How the program protects against possible conflict of interest when referrals are made to the private practice of your own staff members?" Judging for the diverse responses, there is no common understanding of a policy to guide such referrals.



For example, of 19 Highland Psychiatric Emergency staff respondents,
37 percent did not answer the question; 32 percent said they provide at least three names for the client's choice; and 33 percent said individuals made referrals as their own judgment dictates since there is no particular policy regarding this.

Of all clinicians, County and contract, who answered our questionnaire:

- 28 percent said they have no particular policy and individuals make referrals as their own judgment dictates;
- 20 percent said no one on their staff has a private practice;
- 19 percent said they provide three names for the client's choice;
- 18 percent did not answer this question;
- 10 percent said it is their policy never to refer clients to the private practices of their own program staff;
- 5 percent make referrals to private practice of their own staff only when a long prior relationship exists between the client and therapist; and even then the client has a clear choice to see another therapist.

While there may be therapeutic benefits a client to continue treatment with a therapist first seen in a County-funded clinic, there is an element of possible conflict of interest which should be safeguarded against. This may not be widespread problem, but ambiguous arrangements need to be resolved. For this reason, the Mental Health administration should confer with County Counsel, and then with Service Chiefs to develop appropriate procedures to protect against possible conflicts of interest.



WE CONCLUDE that current community resource information is not generally available to many program staff members.

WE RECOMMEND that Service Chiefs assign responsibility of staff members to collect and routinely update centrally available community resourced information.

FINDINGS AND SUPPORT:

Our site visits and questionnaires revealed that many programs do not keep resource files up-to-date. The absence of current files of community resources limits the degree to which the County can appropriately utilize reources. Most staff members develop their own lists or informally share information. This is workable in small programs with good staff communication, but where there are many staff members working independently, and especially in programs with training students, community resource information must be routinely updated and systematically shared through a central file (see Volume III, Mangement Site Evaluations for particular program with and without community resource files).

We urge the Mental Health Director to reiterate to all services the State legal requirement to maintain community resource files, and to monitor the progress of services in developing updated files.

WE CONCLUDE that most programs do not have effectively organized program manuals.

WE RECOMMEND that the Service Chiefs develop more thorough program manuals, especially for large staffs, so routine program functions are clearly understood, and job responsibilities are clearly identified.



WE COMMEND the Asian Community Mental Health Services and El Centro de Salud Mental for their outstanding program manuals.

FINDINGS AND SUPPORT:

In general, written program manuals are often outdated or not effectively organized and available to staff members. This is a critical deficiency for programs where there are more than eight staff members, or where training students are placed.

Several programs have provided remarkably complete program manuals; Highland Inpatient and Emergency Services, for example, and Gladman Day Treatment. El Centro and Asian Community Mental Health Services have outstanding program manuals which could serve as models for other services.



SUPERVISION

Supervision is defined as staff support and training which strengthens the employees' ability to perform, corrects necessary elements, and improves service delivery. Employee performance evaluation are an obvious management tool which can identify job expectation for employees, point out areas for improvement, and recognize individual abilities. Performance evaluations are also useful as tools for screening out staff whose training, initiative and/or personal styles are not suited to the jobs they are expected to perform.

WE CONCLUDE that supervisory skills and staff support are generally weaker among Service Chiefs who have been trained as clinicians only.

WE RECOMMEND management training in supervisory skills for Service Chiefs and line supervisors.

WE CONCLUDE that supervisory positions are sometimes awarded County employees on the basis of seniority, not on supervisory skills. This can weaken staff support.

WE RECOMMEND that supervisory skills be considered, first and foremost, in employees' promotions to supervisory jobs.

WE COMMEND the recent efforts to implement a County employee performance evaluation system.

FINDINGS AND SUPPORT:

Based on our Service Chief interviews and site evaluations, we find that clinicians are not generally trained in supervising skills.



Their professional experience more often leads them to identify with personal problems of poorly performing employees, instead of identifying with the overall program's functioning. Necessary staff changes are neglected or left unresolved, and this weakens staff support. (See "Training" in an earlier section of this report for a fuller discussion of training needs for supervisory skills.)

Clinicians answered our question "Is the supervision you receive of real value to you in the performance of your job?" as follows:

It is of real value to:

63% of the contract employees
44% of the County employees

It is mostly valuable to:

25% of the contract employees
27% of the County employees

It is only somewhat valuable to:

8% of the contract employees
17% of the County employees

It is of almost no value to:

2% of the contract employees
10% of the County employees

Supervision is consistently rated lower by County employees.

Performance evaluations are not regularly used as a management technique to assess and improve employee performance. Contract employees more

often receive evaluations, although this varies among different programs.

We find that 26 percent of the County Service Chiefs (5 respondents) did not know who held responsibility for completing performance evaluation for them, and 18 percent of contract Service Chiefs (3 respondents) did not know. Seventy-four percent of the County Service Chiefs said they had never had an evaluation as Service Chief, while 41 percent of the contract Chiefs said they had not had one.

So long as there are no defined ways of evaluating supervision, staff support is weakened, and effective delivery of service will be impaired. There is a new employee performance evaluation system being implemented in County programs, and this may help to improve County supervision.

Site evaluations show that supervisory positions are sometimes given to County employees on the basis of seniority in County programs. Without the Service Chief evaluating supervisory skills, and making necessary changes, supervision is weakened.

WE CONCLUDE that County personnel procedures impede personnel changes that may improve supervision.

WE RECOMMEND that Regional Directors, when necessary, provide sustained support to Service Chiefs who must accomplish difficult staff changes, such as especially employee dismissals.



FINDINGS AND SUPPORT:

Personnel regulations and reclassification procedures make it difficult for County Service Chiefs to accomplish personnel changes such as reassigning personnel to more appropriate positions, or discharging staff, if necessary.

According to a majority of the County Service Chiefs, it usually takes nine months or more to reclassify a position. Thirty-seven percent of the County Chiefs said they "often" have difficulties in recruitment and hiring. Of the contract Service Chiefs responding, 71 percent said they "sometimes" have recruitment and hiring difficulties, while 25 percent said they "never" did.

WE CONCLUDE that the County personnel freeze has weakened supervision, especially in Rehabilitation Services.

WE RECOMMEND that supervisory positions be filled immediately in Rehabilitation Services.

FINDINGS AND SUPPORT:

The County personnel freeze has had an unfortunate impact on program staff, especially in Rehabilitation Services where supervisory positions have been vacant for months. This has most notably influenced staff support in East Oakland and Central Rehabilitation Services.

This is supported by our site evaluations in Volume III and from interviews with staff.

PROGRAM ANALYSIS

Program analysis is a method of learning from past experiences. It is essential for program correction and improvement. Through evaluation techniques, information is generated for program decisions. Goals can be formulated, and measurable objectives can be identified for accomplishment within a given time. In this way, activity is placed within a priority system, and choices and improvement are more clearly understood.

WE CONCLUDE that program analysis need to be developed in most mental health programs.

WE COMMEND Mental Health advocates, Parental Stress, and Asian Community Mental Health Services for developing good foundations for program review; along with Tri-City Rehabilitation Service, Central Rehabilitation Service, and Probation Guidance Clinic.

WE RECOMMEND that management training be provided for Service Chiefs to develop program review techniques.

WE RECOMMEND that management support be provided through the Mental Health Planning Office and Program Evaluation Unit for County Programs.

WE RECOMMEND further that Regional Directors consider program review to be a management responsibility of each Service Chief.

FINDINGS AND SUPPORT:

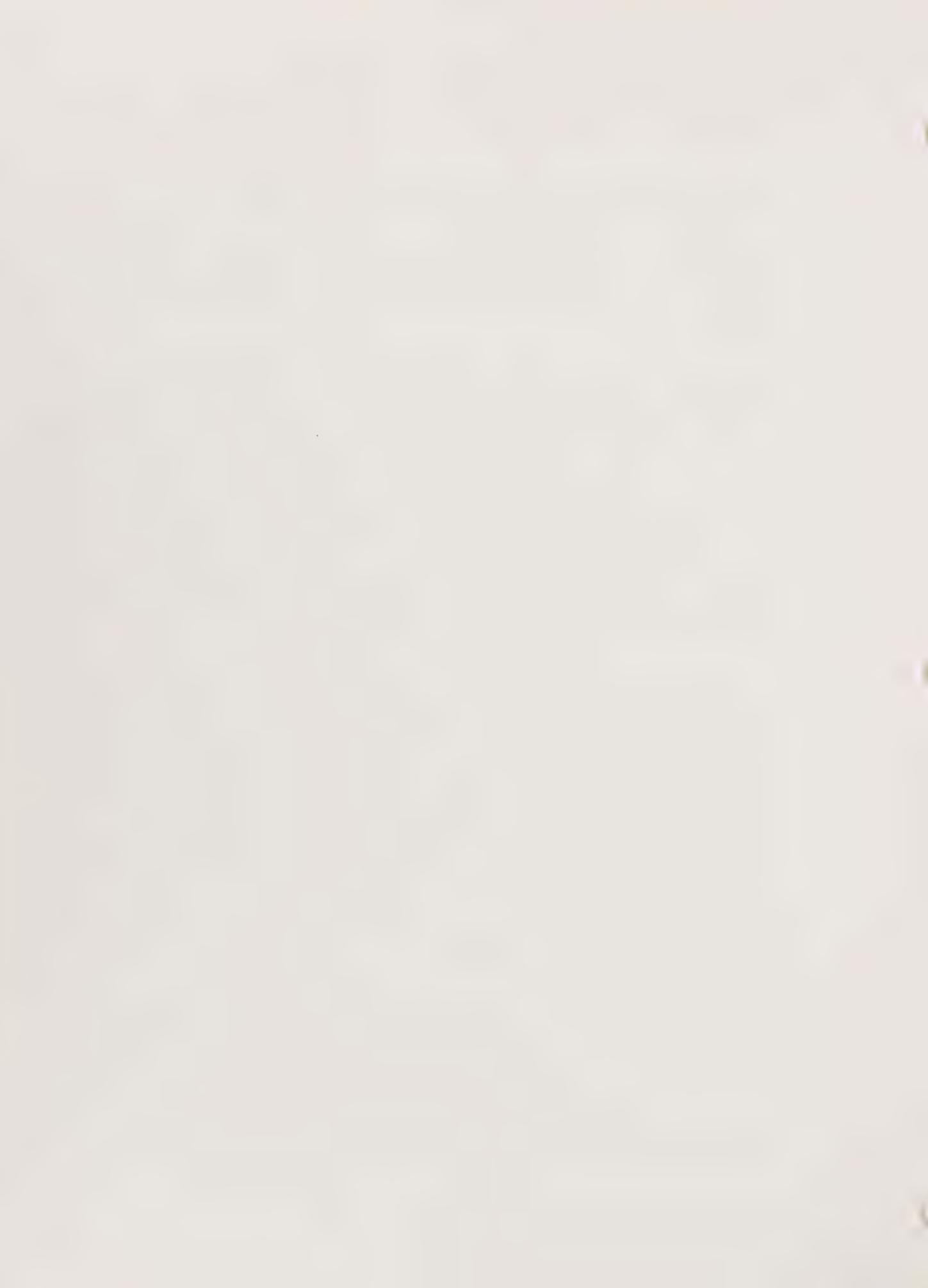
In general, we find that very few programs have developed the capacity for program review. Throughout our site evaluations and interviews, we asked for examples of program objectives which are used to guide the site's development, and to permit program evaluation. Most program

Service Chiefs offered only the biostatistics (required by State law) as their way of monitoring progress. The biostats count admissions and discharges, and units of service. This is a rudimentary base for program review.

There is an attitude among some clinicians that evaluation "can't be done" for mental health services, that each client case must be reviewed on its own terms. Whereas individual case review may require individually tailored objectives for evaluation, a responsible manager must consider the program's accomplishments as a unit. The Service Chief and staff can most appropriately design program objectives which identify relevant changes for improvements in their service.

We understand that direct client service rightfully takes priority over program analysis especially in programs working with clients in acute phases of illness. However, this does not preclude the Service Chief's requesting help from the Mental Health's Program Evaluation Unit or arranging a clinic workshop once a year to develop objectives and to identify what data need to be collected to outline a program's accomplishment, beyond the routine biostats.

We conclude that most Service Chiefs do not recognize management techniques of objective setting, and of review of the program, as a whole. Program analysis can take the form of an annual progress report (but not a public relations document); it may be a list of objectives to be



accomplished in the next year; or it may be formal research on client caseloads with the intention of providing information that can improve service.

In general, we find contract programs are subjected to evaluations (required by their multiple funding sources). With this experience, contractors have developed more review techniques than County programs. However, this is often pro forma compliance rather than the development of true on-going review process for management decisions.

There are several programs which are notable exceptions and deserve special credit for developing program review techniques; for instance, Mental Health Advocates, Parental Stress, and Asian Community Mental Health Services have developed good foundations for program review and planning.

Tri-City Rehabilitation Service, Central Rehabilitation Service, and Probation Guidance Clinic are good examples of County programs which do program review.

ADMINISTRATIVE AND FINANCIAL SUPPORT

ADMINISTRATIVE AND FINANCIAL SUPPORT

Summary of Conclusions and Recommendations

WE CONCLUDE

that the level of administrative and financial support provided by the Health Care Services Agency is seriously inadequate and inhibits the delivery of effective mental health services.

WE RECOMMEND

- (1) That the Health Care Services Agency develop goals and objectives that clearly identify the role of its staff members in the provision of administrative and financial guidance to mental health.
- (2) That the publication of the HCSA - proposed administrative policies and procedures manual be given top priority so that it can be dispersed throughout the Health Care Services Agency to assist in the provision of administrative and financial guidance.
- (3) That steps be taken by the Agency Director to determine what is needed to strengthen the capacity of the Finance Department of HCSA to provide adequate financial support to Mental Health Services
- (4) That an individual or unit be assigned full responsibility for grants administration, preparation, or assistance and monitoring within the Agency.

WE CONCLUDE

that the lack of strong communication links between the Auditor's Office, the Finance Division of HCSA, and Mental Health Services budget personnel may have cost the County \$500,000 in reimbursable indirect costs from the State Department of Health for FY 73-74 and \$1.3 million for FY 75-76.

WE RECOMMEND

that personnel from the Auditor's Office, the Finance Division of HCSA, and Mental Health Services work closely together in preparing claims for reimbursement from the State Department of Health. We further recommend that clearly understood roles and lines of accountability be established for this annual task.

- WE CONCLUDE that frequent time delays reduce the quality of services provided to Mental Health Services by the General Services Agency.
- WE RECOMMEND that clearly defined procedures be adopted, and accountability be established in the General Services Agency, Health Care Services Agency, and Mental Health Services, to process and monitor Mental Health's requests for GSA services.
- WE CONCLUDE that no written procedures or guidelines exist to inform users (e.g., mental health) on how to obtain services provided by the General Services Agency.
- WE RECOMMEND that high priority be given by GSA to the publication and dispersal of a procedural manual to provide definitive and consistent guidelines on the proper utilization of the various divisions within the General Services Agency.
- WE CONCLUDE that mental health administrative and budget staff have an insufficient role in the CAO's budget review process, and that communication among the key parties needs improvement.
- WE RECOMMEND that Mental Health Services, HCSA, and the CAO's staff follow-up budget-related decisions in writing, in a timely manner, to ensure that all parties involved properly understand the decisions.
- WE CONCLUDE that excessive time delays in the examination, classification, and recruitment processes for personnel have hampered the delivery of mental health services.
- WE RECOMMEND that Mental Health Services make their requests of the Personnel Department with a reasonable amount of lead time to avoid delays. We further recommend that personnel analysts keep HCSA and Mental Health Services abreast of the status of mental health personnel requests via increased written and timely communications.
- WE CONCLUDE that arbitrary actions by the State Department of Health and uncoordinated State and County budgetary cycles have hampered Alameda County's Mental Health Service in its attempts to plan services, forecast needs, and reduce State hospital utilization.
- WE RECOMMEND that the Board of Supervisors prepare a memorandum of concerns to be addressed to the State Department of Health and to lobby for increased coordination of budgetary cycles so that Mental Health Services can effectively plan the use of available funds.

ADMINISTRATIVE AND FINANCIAL SUPPORT

Introduction

1. The Importance of the Issue

The delivery of any major service must rely upon strong administrative and financial support. Since Mental Health Services in Alameda County are delivered in 50 different locations, need for coordinated and reliable support is critical. Increased demands for Mental Health Services necessitates the clear identification of issues, procedures and guidelines from those County agencies called upon to provide support to the delivery of services. Yet our analysis indicates that unclear definitions of administrative and financial support procedures, faulty and untimely reporting and certain policies all help serve to impair the capacity of the County and contracted Mental Health Services to plan and efficiently deliver Mental Health Services.

2. Our Approach

In the course of our analysis, the evaluation team conducted interviews with Mental Health Services management and administrative staff and with key personnel in the agencies primarily responsible for providing administrative and financial support to Mental Health Services. In addition to intensive interviewing, specific questions relating to support issues were placed in the staff questionnaires administered to all clinical, clerical personnel, and chiefs of service.

The combination of initial overview interviews, questionnaire data, subsequent issue-oriented interviewing, and review of documents provided the basis for the discussion that follows.



3. Organization

The conclusions, recommendations, and supportive findings for this issue are provided under four relatively discrete categories:

- a) The relationship of HCSA to Mental Health Services.
- b) The effects of the County's administration of A-87 overhead costs on Mental Health Services.
- c) The effects of poor communications between Mental Health Services and Support Services.
- d) The effects of the State Department of Health's Decisions and Procedures on local Mental Health Services.

The focus of our analysis is on the relationship of Mental Health Services to the Health Care Services Agency, the Auditor-Controller's Office, the County Administrator's Office, the General Services Agency, the Personnel Department, and the State Department of Health. What follows are specific conclusions and recommendations with a support statement for each pair.



A. RELATIONSHIP OF HCSA TO MENTAL HEALTH SERVICES

Conclusions and Recommendations

WE CONCLUDE that the level of administrative and financial support provided by the Health Care Services Agency is seriously inadequate and inhibits the delivery of effective mental health services.

WE RECOMMEND that the Health Care Services Agency develop goals and objectives that clearly identify the role of its staff in the provision of administrative and financial guidance to mental health.

SUPPORT:

The Health Care Services Agency has done a poor job of defining its relationship to Mental Health Services. HCSA studies and OPE interviews indicate that several mental health service chiefs do not know how to use the services provided by HCSA.

A recent study of Administrative Services in the HCSA, conducted by William Jacobson, substantiated this point:

"Throughout our interviews and inherent with practically all of our findings is the need for goals and objectives, role definitions, and effective communication."

WE RECOMMEND that the publication of the HCSA proposed administrative policies and procedures manual be given top priority so that it can be dispersed throughout the Health Care Services Agency to assist in providing administrative and financial guidance to Mental Health Services.



SUPPORT:

The absence of clear-cut Agency policies and procedures has resulted in mental health staff initiating independent actions that were either inconsistent, duplicative, incorrect, or unnecessary.

For example, our data shows that a child psychiatrist in one of the mental health clinics was involved in a process that took over three months to get the correct procedures to order play therapy equipment for a children's clinic.

WE RECOMMEND that steps be taken by the Agency Director to determine what is needed to strengthen the capacity of the Finance Division of HCSA to provide adequate financial support to Mental Health Services.



SUPPORT:

We found the services provided by the Finance Division of HCSA to be, for the most part of little use to Mental Health Services.

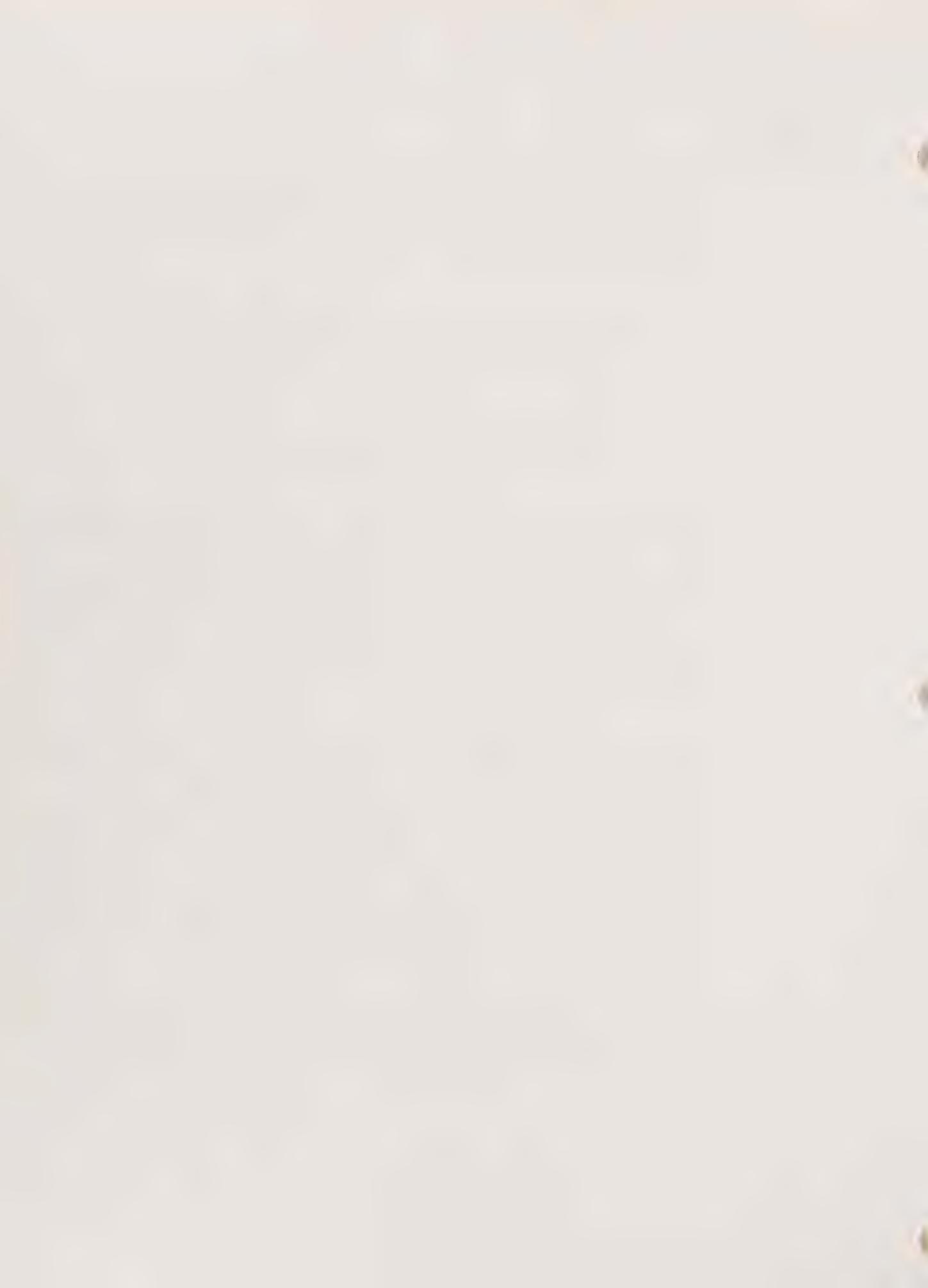
Our analysis indicates that:

1. The equipment used by the Finance Division is inadequate to handle the existing workload.
2. Reports are untimely.
3. Cost center reports are inaccurate.

The workload of the Finance Division is still heavily backlogged after installing new equipment two years ago to offset this workload. The interfacing of new County programs into the accounting system has been given priority consideration over many of the divisions routine activities.

Two mental health services have set up accounting systems within their own services to keep track of their spending levels. In both cases, the individuals doing the accounting work were originally hired to perform other duties. This means the jobs they were hired to perform are either getting done during spare time, being done by other staff members, or are not being done at all.

WE RECOMMEND that an individual or unit be assigned full responsibility for grants administration preparation, assistance, and monitoring within the Agency.



SUPPORT:

HCSA has delegated no responsibility for a grants administration program in the Agency. No individual or unit has been designated to:

1. Provide grant application assistance.
2. Keep abreast of grant monies available from the various funding sources.
3. Set up clear policies and procedures; and
4. Set up an effective monitoring system (since the system currently being used by HCSA has not proven to be effective).

Our analysis of this issue was substantiated again by the Jacobson study:

"The entire activity of grants is handled in a fragmented manner with each service and/or region often handling the application, renewal, and evaluation process independently."



B. THE EFFECTS OF THE COUNTY'S ADMINISTRATION
OF A-87 OVERHEAD COSTS ON
MENTAL HEALTH SERVICES

WE CONCLUDE that the lack of strong communication links between the Auditor's Office, the Finance Division of HCSA, and Mental Health Service's budget personnel may have cost the County \$500,000 in reimbursable indirect costs from the State Department of Health for FY 73-74, and \$1.3 million for FY 75-76.

WE RECOMMEND that personnel from the Auditor's Office, the Finance Division of HCSA, and Mental Health Services work closely together in preparing claims for reimbursement from the State Department of Health. We further recommend that clearly understood roles and lines of accountability be established for this annual task.

SUPPORT:

Mental Health's A-87 overhead costs are calculated by the Auditor's Office. HCSA's Finance Division submits mental health's reimbursement claims for indirect costs to the State Department of Health without any input from the Auditor. Had there been more interaction between these offices prior to processing the reimbursement claims, the problems with State disallowances of indirect costs submitted by Mental Health would have been kept to a minimum. For example:

In June of 1975 Mental Health Services was notified by the State Department of Health that their A-87 reimbursement (approximately \$500,000) was being disallowed. The State's reason for this disallowance was that the A-87 figure was not included in the County's CR/DC report and, therefore, was considered an unbudgeted cost.



OPE concurs with mental health staff who feel that this situation could possibly have been avoided had the Auditor's Office assisted in processing the claim. As evidence of the importance of this issue, the State is currently questioning Mental Health's rapid annual increase in indirect costs (which rose from \$330,910 in FY '72-73 to \$1.3 million dollars in FY '75-76). The County has been told by the State to operate at the same allocated funding level utilized in FY '73-74 allowing for reasonable costs of living increases for FY '74-75 and FY '75-76 until the State receives and accepts the required justification for the increases. Our analysis indicates that the following sequence of events resulted from this action by the State:

1. September 12, 1975; A request was made by the Finance Division to the Auditor's Office to provide the necessary information to support the inclusion of A-87 costs at the \$1.3 million level.
2. October 7, 1975; The Auditor's Office submitted to the Finance Division the impossibility of composing documents used to claim in previous years. The following reasons were cited by the Auditor:
 - a. Provider Cost Report data could not be used because the same departments were not claimed in any of the preceding years.
 - b. Allowable overhead for budgets 301, Highland Hospital, and 303, Fairmont Hospital ('73-'74), were extracted from Medi-Cal cost reports and, there is no comparability between the information obtained from the Medi-Cal reports and amounts that should have been used from the indirect proposals.



- c. Salaries and benefits listed in the '75-'76 computation of A-87 costs could not be composed with salaries and benefits used to compute '75-'76 indirect rates.*
- 3. November 4, 1975: The HCSA Financial Division met with the State Department of Health representative to discuss the format and information required by the State, specifically:
 - a. What caused the increases in County overhead costs?
 - b. How were the increases affected by the amount rolled forward (adjustment for indirect charges not recovered in past years)?
 - c. How were the increases affected by changes in the County's budgeting procedures in mental health and substance abuse programs.?
- 4. November 26, 1975: Finance Division notified the Auditor of format that the State had requested.
- 5. December 8, 1975: Auditor provided Finance Division with a report that compared mental health services indirect costs of past years with those of FY 75-76.
- 6. January 6, 1975: The Auditor's Office submitted a letter to the Finance Division of HCSA with the information requested by the State in the suggested format.

The information was submitted to the State, and as of March, 1976 there has been no response from the State.

This sequence of events could have been avoided, or at least, minimized below the four-month processing period, had the County personnel involved in this transaction been diligently involved in the preliminary stages of the budget process and the reimbursement claims proceedings.

* The official from the Auditor's Office then suggested that indirect rate proposals be compared to provide comparable overviews with comparable control totals. The Auditor official then requested the type of format needed, in which to supply the information, and what information and comparisons were needed.

C. THE EFFECTS OF POOR COMMUNICATIONS BETWEEN
MENTAL HEALTH SERVICES AND
SUPPORT SERVICES

WE CONCLUDE that frequent time delays reduce the quality of service provided to Mental Health Services by the General Services Agency.

WE RECOMMEND that clearly defined procedures be adopted, and accountability be established in the General Services Agency, Health Care Services Agency, and Mental Health Services, to process and monitor Mental Health requests for GSA services.

SUPPORT:

Interviews with mental health management and questionnaire responses reveal several problems relating to the General Services Agency.

Complaints arise over:

1. Time delays while waiting for purchase orders to be filled.
2. Problems in getting repair work completed.
3. Problems expediting purchase orders.
4. Difficulties with the County mailing system (pre-QIC code).
5. Problems with the space leasing program.

Those mental health staff members experiencing few problems receiving services from General Services Agency unanimously attributed their success to being in the County service long enough to know personnel in other departments to assist them in getting direct services.

WE CONCLUDE that no written procedures or guidelines exist to inform users (e.g., mental health) on how to obtain services provided by the General Services Agency.

WE RECOMMEND that high priority be given by GSA to the publication and dispersal of a procedure manual to provide definitive and consistent guidelines on the proper utilization of the various divisions within the General Services Agency.

SUPPORT:

Our data shows that the major complaints within Mental Health regarding GSA pertain to the services provided by the Building Maintenance Division. Interviews revealed that there was no written request procedures for requesting service. Work requests were generally accepted verbally only. Our questionnaire data shows that 61% of the County Mental Health Service Chiefs are dissatisfied with Building Maintenance services.

At present, GSA procedure manuals do not exist. This is a contributing factor to the complaints of inconsistent procedures used to order equipment and supplies.

WE CONCLUDE that mental health administrative and budget staff have an insufficient role in the CAO's budget review process and that communication among the key parties needs improvement.

WE RECOMMEND that Mental Health Services, HCSA, and the CAO's staff follow-up budget related decisions in writing, in a timely manner, to ensure that all parties involved properly understand the decision.

SUPPORT:

Mental Health's concerns with the CAO's budget processes include:

1. Lack of communication during the budget review process between the CAO analyst and mental health budget personnel.
2. Lack of timely feedback to Mental Health Services of CAO decisions prior to submission to the Board of Supervisors.
3. Disagreements resulting from analysts' lack of the specific program knowledge required to make good decisions on mental health program requests.

For example, our analysis shows that poor communication between the CAO analyst and mental health budget personnel has caused the reconciliation of State allocations by the County to be late. Earlier this fiscal year, the CAO analyst deleted \$150,000 from one mental health budget without properly notifying the mental health budget personnel. As a result of this, the reconciliation was late, the reimbursement claims were delayed, and the County cash flow was adversely affected.

WE CONCLUDE that excessive time delays in the examination, classification, and recruitment processes for personnel have hampered the delivery of Mental Health Services.

WE RECOMMEND that the Mental Health Services make their requests of the County Personnel Department with a reasonable amount of lead time to avoid delays. We further recommend that personnel analysts keep HCSA and Mental Health Services abreast of the status of mental health personnel requests via increased written and timely communication.

SUPPORT:

Excessive time delays on examination and classification actions were a major concern of the mental health staff.

Stronger feelings were relayed to OPE concerning the length of time necessary to get a position reclassified. Our questionnaire data indicated that 58% of the 19 service chiefs questioned felt it took nine months or more to get a position reclassified. 15% felt it took at least four to eight months to get a position reclassified.

Personnel analysts were generally considered to be slow and uncooperative with the mental health staff. Another major complaint of the mental health staff concerned the "rigid and inflexible" Civil Service rules and regulations which make it very difficult to do any type of emergency or affirmative action hiring.

In partial response to these problems, the Personnel Department reorganized their staff at the beginning of this fiscal year in an effort to provide better services to user departments. One major change came with the division of the analyst staff into three separate sections: (1) examination and recruitment; (2) classification; (3) direct services.

Direct services analysts perform the full range of personnel duties for those departments, within the County, that either elect not to get involved in performing examination and classification functions within their own department or are too small to perform these functions. Additionally, a variety of administrative controls have been implemented to monitor workloads and decrease delays. These changes along with others, could be instrumental in cutting down the response time in providing personnel services.

Our analysis indicates that recruitment delays could result from any of several reasons including:

1. Difficulty finding qualified candidates.
2. Mental Health or Health Care Services giving insufficient advance notice to allow the recruitment processes to properly work for them.
3. Lack of funds to do appropriate advertising.

Since many changes in the Civil Service Rules and Regulations require a charter amendment, an election would be necessary to change the system. Until this occurs, mental health, as well as other agencies, will continue to have problems meeting affirmative action goals and will still select from the top three available candidates on an eligibility list to fill a vacancy.

D. THE EFFECTS OF THE STATE DEPARTMENT OF HEALTH'S
DECISIONS AND PROCEDURES ON LOCAL
MENTAL HEALTH SERVICES

WE CONCLUDE that arbitrary actions by the State Department of Health and uncoordinated State and County budgetary cycles have hampered Alameda County's Mental Health Service in its attempts to plan services, forecast needs, and reduce State hospital utilization.

WE RECOMMEND that the Board of Supervisors prepare a memorandum of concerns to be addressed to the State Department of Health and to lobby for increased coordination of budgetary cycles so that Mental Health Services can effectively plan the use of available funds.

SUPPORT:

Our interviews with local and State officials reveal the following problems encountered by Mental Health Services with the State Department of Health:

1. The State and the County operate under different budget cycles, making it difficult for our County Mental Health Services to plan programs according to firm funding limits.
2. Deficits have resulted from having to put a County mental health budget together before State dollars are made available.
3. The State Department of Health very often does not provide clear instructions to the local mental health program.
4. State analysts are often uncertain of procedures and guidelines submitted from the State Department of Health and are, therefore, unable to offer relevant and timely assistance to County Mental Health Services.



EFFECTS OF PRESENT BILLING AND LIABILITY PROCEDURES ON COUNTY-OPERATED
AND CONTRACTED MENTAL HEALTH SERVICES



EFFECTS OF PRESENT BILLING AND LIABILITY PROCEDURES ON COUNTY-OPERATED
AND CONTRACTED MENTAL HEALTH SERVICES

General Conclusions

WE CONCLUDE that the Alameda County Mental Health Service should have generated at least \$793,900 additional revenues, than were collected in the fiscal year of 1974-75. Revenues were not maximized in three areas:

- 1) At least \$354,000 was forfeited in Short-Doyle Medi-Cal revenues.
- 2) If the Mental Health Service had been able to collect at the average rate of other California Counties in patient fees, the additional revenues would have been \$202,100.
- 3) If the Mental Health Service had been able to collect at the average rate of other California Counties in private insurance, the additional revenues would have been \$237,800.

WE CONCLUDE that the Alameda County Mental Health Service may fail to generate as much as \$1,118,600 additional revenues during fiscal year 1975-76, if the present trend continues. These additional revenues consist of the following:

- 1) As much as \$640,000 may be forfeited in Short-Doyle Medi-Cal revenues.
- 2) If the Mental Health Service continues to collect the same percentage of patient fees and private insurance in fiscal year 1975-76, as it did in fiscal year 1974-75, as compared to the average rate of other California Counties, the Mental Health Service will fail to generate \$219,900 in patient fees and \$258,700 in private insurance.

SUPPORT: We believe that our entire analysis supports the above general conclusions. We present here supporting calculations.

1. Medi-Cal Revenues

The underutilization figures of \$354,000 and \$640,000 were supplied by HCSA. Our analysis shows that it would have been possible for the Mental Health Service to collect these additional revenues



without serving additional patients, and that steps can be taken during this fiscal year to generate more of these revenues that was expected.

2. Fiscal Year 1974-75: Patient Fees and Private Insurance

The State Department of Health expresses revenue collection as a percent of gross program. Refer to Chart I, page 37. During fiscal year 1974-75, the collection rate for patient fees and private insurance in this County was 1.7 percent and 2.0 percent, respectively, below the State-wide average rates of collection.

CALCULATION

$$\text{Patient Fees} - (2.1\% - .4\%) = 1.7\%$$

$$1.7\% \times \$11,887,883 = \$202,094 \text{ or approx. } \$202,100$$

$$\text{Private Insurance} - (2.7\% - .7\%) = 2.0\%$$

$$2.0\% \times \$11,887,883 = 237,758 \text{ or approx. } \$237,800$$

3. Fiscal Year 1975-76: Patient Fees and Private Insurance

For fiscal year 1975-76, the adjusted gross cost of the Mental Health Program is \$12,934,602. Hence, if the present rate of collection continues the following will calculate dollars which the Mental Health Service will fail to generate in fiscal year 1975-76.

CALCULATION:

Patient Fees - 1.7% x \$12,934,602 = 219,888 or approx. \$219,900

Private Insurance - 2.0% x \$12,934,602 = \$258,692 or approx. \$258,700

EFFECTS OF PRESENT BILLING AND LIABILITY PROCEDURES ON COUNTY-OPERATED
AND CONTRACTED MENTAL HEALTH SERVICES

Summary of Conclusions and Recommendations

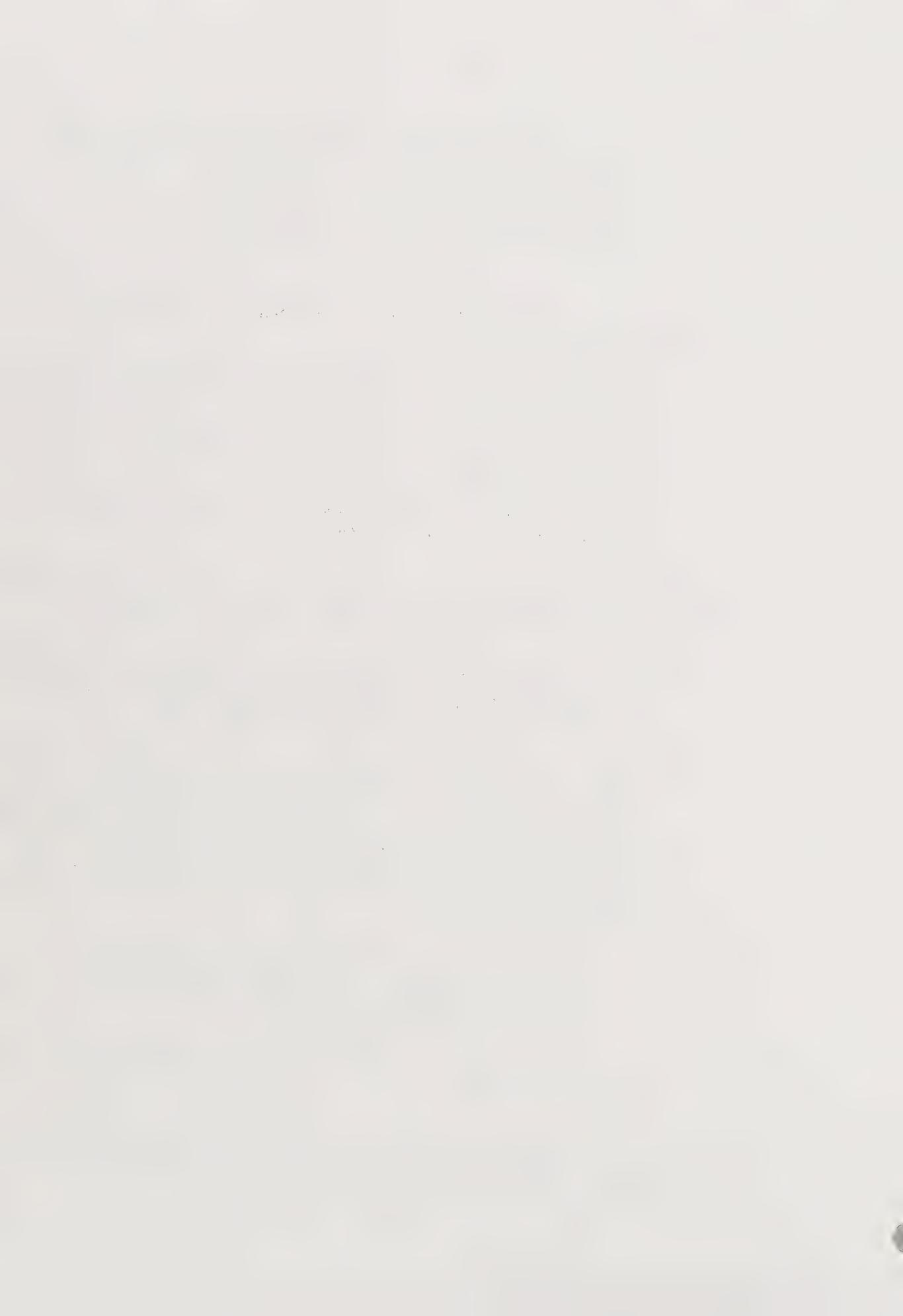
WE CONCLUDE that the reasons why Mental Health revenues were not maximized include the following:

- The present billing and accounts receivable system used by Health Care Services Agency is inadequate for Mental Health.
- Contracted services do not have sufficient incentives to collect Short-Doyle Medi-Cal monies.
- Contracted services are not rigorously monitored regarding their efforts to pursue revenues.

WE RECOMMEND that Health Care Services Agency and the Mental Health Administration take action to maximize revenues in the following ways:

- Health Care Services Agency efforts to implement a new billing and accounts receivable system should include more input from the Mental Health Administration to ensure that any system selected is appropriate for Mental Health needs.
- Health Care Services Agency and the Mental Health Administration should take action to increase utilization of Medi-Cal. In addition to recommendations made elsewhere in this Issue, which will influence Medi-Cal collections, Health Care Services Agency and the Mental Health Administration should investigate the advantages of using more patient services technicians. The Mental Health Administration should also do one or both of the following during this fiscal year:
 - 1) "Swap" part of its Medi-Cal appropriation for Short-Doyle appropriation. This "swap" is made with contractors who believe that they can collect the additional MediCal dollars.
 - 2) Buy out part of the Medi-Cal appropriation at \$.68 on the dollar.

WE RECOMMEND that the Mental Health Administration rigorously monitor contracted services regarding their efforts to pursue revenues.



- 5 -

WE RECOMMEND that Mental Health Service use a standardized insurance claim form which can be completed at the treatment facility rather than depending on the patient to bring in a claim form from his/her insurance company, as is presently done.

WE RECOMMEND that the County Administrator's Office be responsible for mandating that administrative coordination exist between Health Care Services Agency and Social Services and between Mental Health Services and Social Services. This coordination will ease Medi-Cal certification and "Proof of Eligibility" label requests.

WE RECOMMEND that the Board of Supervisors direct the County Administrator's Office to investigate the possibility of reimbursing contracted services for Short-Doyle Medi-Cal monies in advance of payment of such monies from the State to the County.

WE CONCLUDE that the UMDAP system presents numerous problems. It is sometimes difficult to implement and it sometimes has effects upon treatment. Some of these problems are basic to UMDAP and would require a change by the State in the mandated procedure.

WE RECOMMEND that the Mental Health Administration make its UMDAP explanation brochure available to County-operated and contracted services in any languages needed.

WE RECOMMEND that the Mental Health Administration increase UMDAP training programs and make this service available to County-operated and contracted services.

WE RECOMMEND that the Mental Health Administration redefine the UMDAP appeals procedures and make all services aware of that procedure so that appeals are reviewed in the same manner throughout the County.

WE RECOMMEND that HCSA efforts and Mental Health Administration efforts related to the previous three recommendations continue in a timely fashion.

WE RECOMMEND that HCSA express cost-of-service rates by various types of service rendered (as opposed to one cost per modality as presently calculated) to make UMDAP more equitable. A nominal fee should be set for first visits in short-term services.

WE RECOMMEND that the Board of Supervisors direct the County Administrator's Office to investigate present cost-of-service rates approved by the Board. These rates are submitted by HCSA for Board approval. If investigation so indicates, rates should be adjusted.

WE RECOMMEND that the Board of Supervisors lobby the State for improvements in UMDAP. We suggest that major problems with fees set for 24 hour residential services be corrected and that a monthly or per session liability be considered. A monthly or per session liability would make UMDAP more workable in short-term services.

WE CONCLUDE that the present billing and accounts receivable system used by HCSA (Special Billing) adversely affects clients.

WE RECOMMEND that HCSA efforts to implement a new billing and accounts receivable system continue with increased input from the Mental Health Administration.

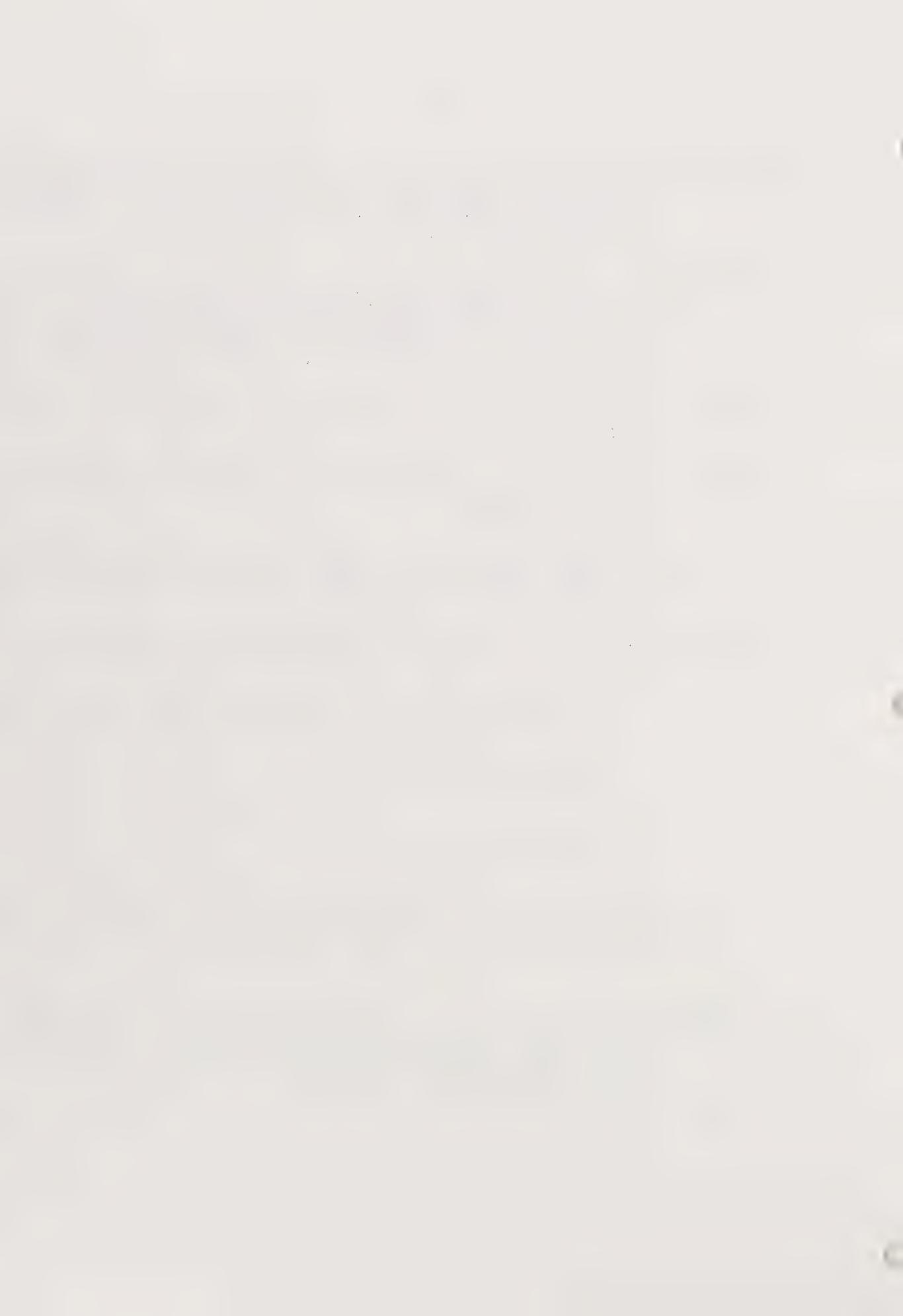
WE CONCLUDE that County-operated and contracted services, and HCSA-Special Billing are in conflict with State policy with respect to certain billing and collection procedures.

WE RECOMMEND that HCSA, the Mental Health Administration, and chiefs of contracted services implement procedures for the following:

- Follow-up procedures for uncollected clients' bills. Follow-up should include consultation with a client's therapist.
- Redetermination of UMDAP liability as frequently as required by State policy.
- Discussion of unpaid liability with the client at the time of his discharge.

The Mental Health Administration should coordinate all efforts to implement such procedures to ensure that procedures comply with State policy regarding Community Mental Health Services.

WE RECOMMEND that the Mental Health Administration have input into decisions made by HCSA - Finance regarding Mental Health to insure that all procedures implemented comply with State policy regarding Community Mental Health Services.



EFFECTS OF PRESENT BILLING AND LIABILITY PROCEDURES ON COUNTY-OPERATED
AND CONTRACTED MENTAL HEALTH SERVICES

A. Introduction

1. The Importance of the Issue

Alameda County Mental Health Service's collections are among the lowest in the State. Numerous procedures adversely affect this County's ability to generate revenues.

The State of California requires that all providers of services to Short-Doyle clients must employ the "Uniform Method to Determine Ability to Pay" Plan (UMDAP).

Problems exist in the implementation of UMDAP. Often Mental Health staff and clients are confused about UMDAP. In some instances the utilization of UMDAP adversely affects treatment. Some of these problems are inherent in the UMDAP plan, whereas other problems could be alleviated by implementation of different County procedures.

Mental Health Service costs for Short-Doyle clients exceeds the State appropriation, for Alameda County. At the same time Alameda County is underutilizing its Short-Doyle Medi-Cal appropriation. It is estimated that for the fiscal year 1974-75, the underutilization of this County's Short-Doyle Medi-Cal appropriation will be \$640,000 (figure supplied by HCSA). Medi-Cal revenues could be increased if certain procedures were implemented.



WE CONCLUDE that the present billing and accounts receivable system used by HCSA is inadequate for Mental Health.

WE RECOMMEND that HCSA efforts to implement a new billing and accounts receivable system should include more input from the Mental Health Administration to insure that any system selected is appropriate for Mental Health needs.

SUPPORT:

Special Billing, which is within HCSA - Finance, prepares bills and maintains individual client accounts for County-operated Mental Health Services. There are numerous difficulties with the present billing and accounts receivable system. Bills are printed by the same data processing system which prepares bills for the County hospitals. Bills must be adjusted manually to accommodate features unique to Mental Health. This manual adjustment is very time-consuming. In the past, patients have been billed as late as one year after service. The format of the bill is very confusing. For example, "Please pay this amount", appears twice, generally followed by two vastly different amounts. The data processing system does not accommodate UMDAP.* Hence, an accounting for patient liabilities must be done manually. For a great portion of last year no patients were billed.

As mentioned in the MediCal section of this Issue, the present billing system can not identify all MediCal patients who received service in a given period of time. A data processing list is generated but must be manually adjusted to include all MediCal patients who received service. Such a list is needed to receive reimbursement of MediCal

*UMDAP refers to the State-mandated "Uniform Method to Determine Ability to Pay" Plan.

monies. Claims have not always been filed in a timely manner because of the extensive manual effort needed to adjust the data processing printout.

Under the present data processing system, the patient's accounts receivable is established for cost-of-service. Manual records are kept on the patient's liability, i.e., what he/she is actually billed. The data processing account receivable can not be reconciled to revenues subsequently received because often revenues do not equal cost-of-service.

To compound the problems, we have observed that Special Billing has difficulty keeping a current address on file for all patients. Special Billing personnel complained that notice of change of address is not forwarded to them from the County-operated services. Our staff questionnaires confirm this, since less than 50 percent of the clerks in County-operated services said that they inform Special Billing of a patient's change of address.

We also noted that no follow-up of uncollected bills has been done for at least one year. This problem is discussed later in this Issue. The effects of the billing system on patients is also discussed later.

When a comparison is made between Alameda County revenues and the State-wide average, it is evident that this County falls short of others in collecting revenues (see chart 1). For example, if this County had collected the State-wide average in patient fees, \$202,100

more would have been collected in Fiscal year 1974-75. As one State interviewed remarked:

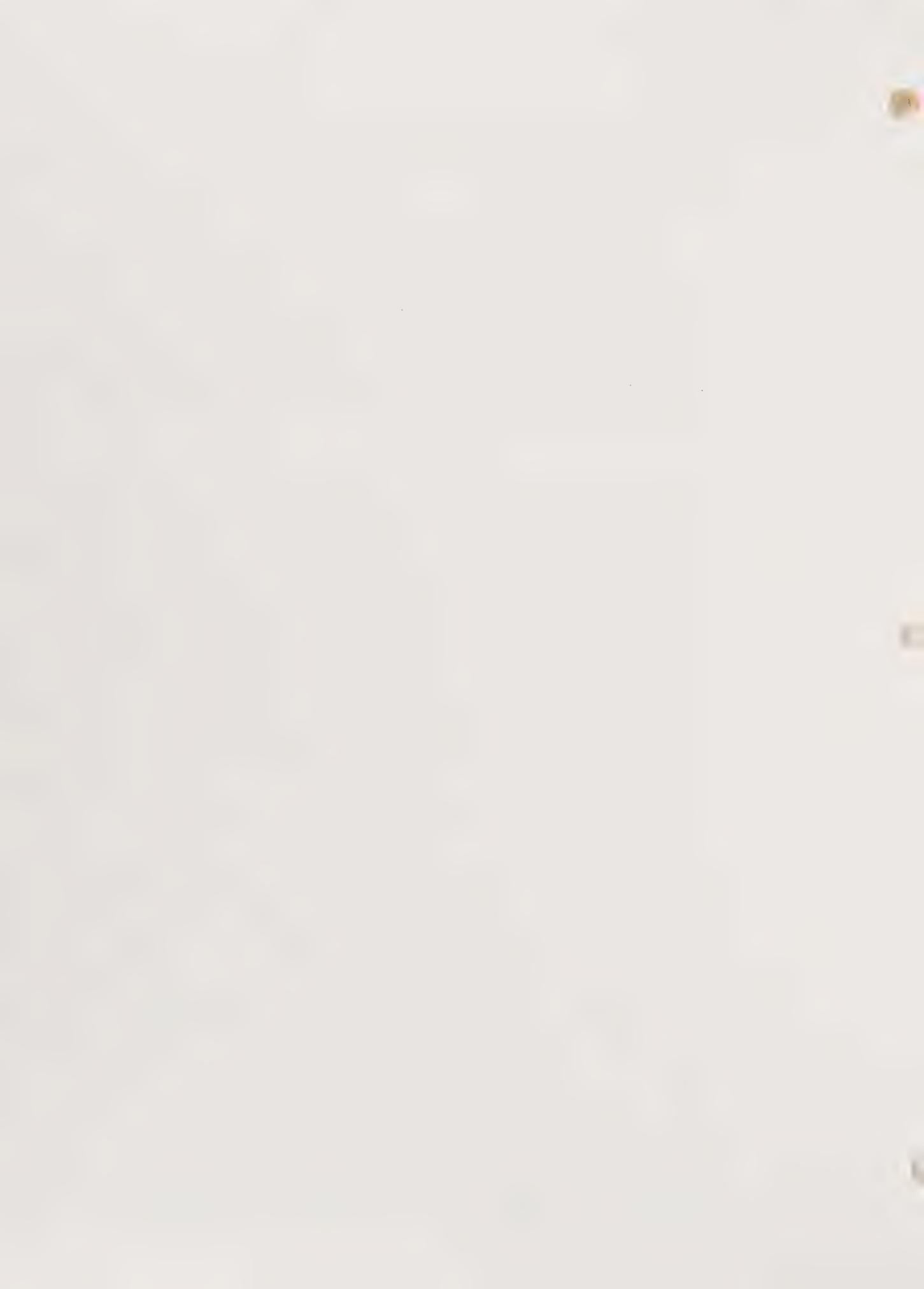
"If you aren't billing people, you can't expect to collect!"

How much is the present system inhibiting the County's ability to collect? It is difficult to say. Certainly a doubling of billing staff has eased the situation. But the enormous manual effort needed is still a hinderance.

The Hospital Automated Systems Project (HASP) was created by HCSA in December, 1974. HASP is concerned with the data collection, billing, accounts receivable, and accounting system for the County hospitals and the medical clinics. HASP is also concerned with the billing and accounts receivable system for Mental Health, Public Health, and Alcohol and Drug Abuse Services. HASP has recognized that the present system has many inadequacies. It was not within the scope of our evaluation to recommend a specific system. Our concern was with the process which is presently leading HASP to a decision.

At the beginning of our evaluation, we were concerned that HASP had not had enough input from the Mental Health Service. In August, 1975, HASP prepared a Request for Proposal (RFP) which listed the needs of any system purchased. Certain Mental Health personnel whom we interviewed did not have input into the preparation of the list of needs. We believe that input from these persons was crucial.

HASP decided to be concerned with Mental Health billing and accounts receivable, not accounting or data collection. Some persons we inter-



viewed questioned the exclusion of an accounting system.

Some interviewees believed that any system purchased should have the capacity for collection of management data. Proposed State-mandated procedures will require the collection of data not presently collected. It was suggested to us that any new system purchased should have the capacity to expand into something more than billing and accounts receivable.

HASP's plan is to allow Mental Health approval of any system selected via the Mental Health/Alcohol, Drug team (MH/AD). MH/AD has examined manual procedures regarding billing and liability within those services. In our view, this channel for Mental Health approval has two weaknesses. One, HASP appears to have a major amount of control over the Request for Proposal. Two, the person on MH/AD representing Mental Health Administration is involved with clerical procedures rather than system analysis.

It is the responsibility of the Local Director of Mental Health to insure that the local program comply with State-mandated procedures, yet no formal procedure was allowed for the Mental Health Director's input into HASP. We believe that the input of the Local Director of Mental Health and/or her representative is crucial to the selection of any system for Mental Health. The Local Director has had informal input into HASP, only because the personalities involved were amenable to this input.



HASP determined that there were several options for a billing and accounts receivable system for Mental Health. These options include the following:

1. Include Mental Health needs in any system purchased for the County Hospitals.
2. Obtain a system from another County-operated Mental Health Service within the State.
3. Develop an in-house system using county personnel.
4. Keep the present system.

HASP generally believed that the latter two choices were least optimum. Early in our evaluation (September, 1975), HASP members whom we interviewed seemed to generally favor the first choice. Most HASP members were not aware of the difficulties of integrating a Mental Health system within a medical system.

HASP met with the various data processing firms which has submitted bids for the entire system (medical institutions, Mental Health Service, etc.). The firms were questioned regarding their ability to accommodate Mental Health needs. To our knowledge, no firm responded in a positive fashion to specific questions raised, concerning Mental Health.

Early in its process, certain HASP members examined other counties to determine what systems other Mental Health Services have. Several counties have what appears to be rather good systems. One county, Fresno, has a modular system, developed with the help of the State. The Fresno system is available at no charge; the only cost is to modify it to interface with other County data processing systems. This system



may be obtained in selected modular sections and expanded if Alameda County wishes to do so.

In March, 1976, members of HASP and certain Mental Health personnel made a site visit to examine the Fresno system. We applaud this inclusion of Mental Health personnel, although it was fourteen months after the inception of HASP.



WE CONCLUDE that the Mental Health Service forfeited at least \$354,000 in Short-Doyle MediCal revenues in fiscal year, 1974-75.

WE CONCLUDE that the Mental Health Service may forfeit as much as \$640,000 in Short-Doyle MediCal revenues in fiscal year 1975-76.

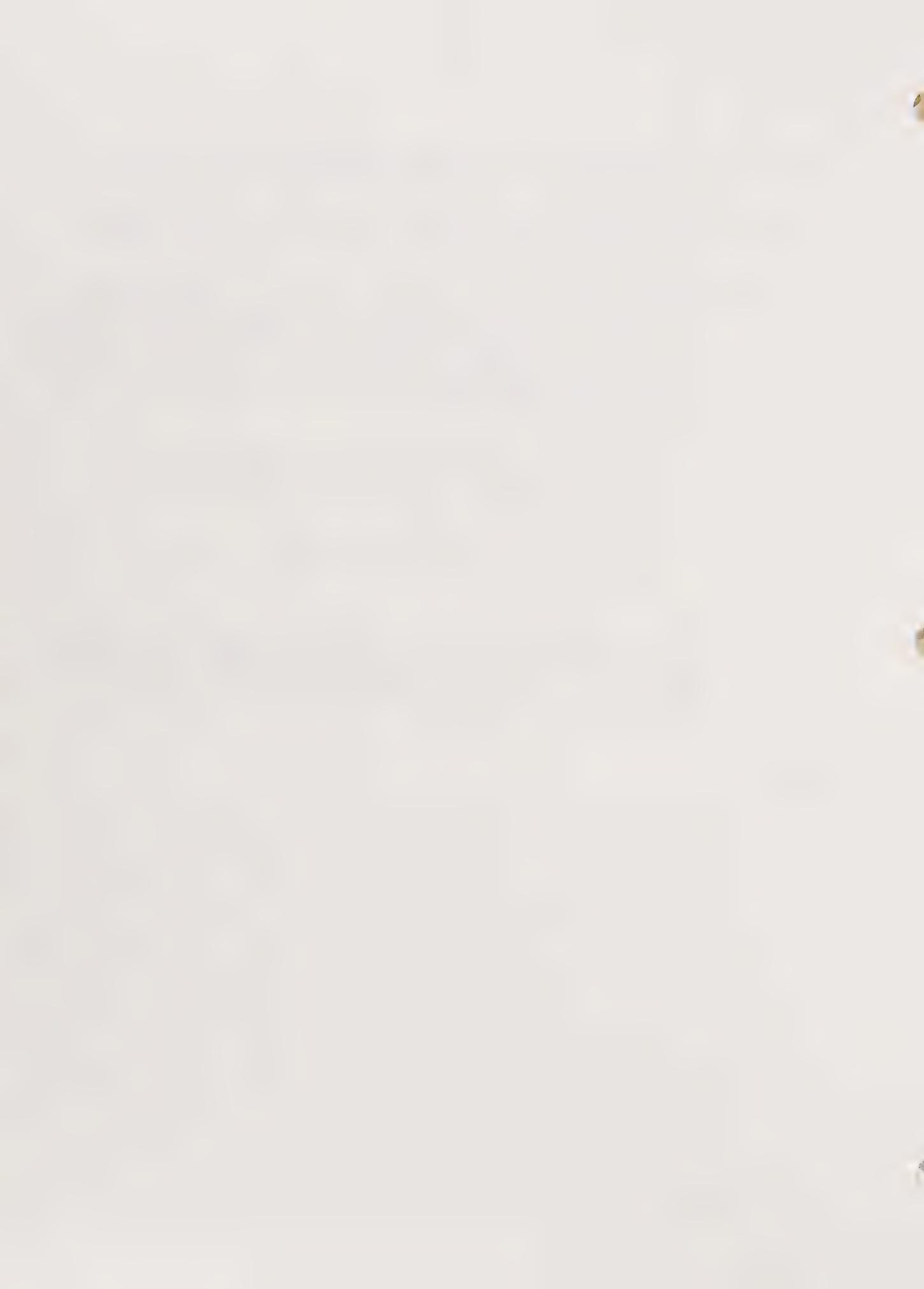
WE RECOMMEND that HCSA and the Mental Health Administration take action to increase utilization of Medi-Cal. In addition to recommendations made elsewhere in this Issue which will influence MediCal collections, HCSA and the Mental Health Administration should investigate the advantages of using more patient service technicians. The Mental Health Administration should also do one or both of the following during this fiscal year:

- 1) "Swap" part of its MediCal appropriation for Short-Doyle appropriation. This "swap" is made with contractors who believe that they can collect the additional MediCal dollars.
2. Buy out part of the MediCal appropriation at \$.68 on the dollar.

WE RECOMMEND that the County Administrator's Office be responsible for mandating that administrative coordination exist between HCSA and Social Services and between Mental Health Service and Social Services. This coordination will ease MediCal certification and "Proof of Eligibility" label requests.

SUPPORT:

If Alameda County is not able to use all of its Short-Doyle MediCal appropriation, it has two alternatives to increase MediCal revenues. One, the County can swap MediCal appropriation for regular Short-Doyle appropriation with one or more of its contractors. In the past, this County has done this - in effect this means swapping MediCal dollars for Short-Doyle dollars with contractor(s) who believe that they can collect more MediCal than was originally allowed in their contract. Two, the County can buy out part of its MediCal appropriation at the rate of \$.68 on the dollar. Alameda County has never done this. A decision to buy out part of the MediCal appropriation at the rate of \$.68 on the dollar



must be made in May of the fiscal year of the appropriation.

In general, Alameda County could increase MediCal revenues in two different ways:

- 1) Pursue the collection of proof of eligibility labels (P.O.E.) from patients on MediCal.
- 2) Identify patients eligible for MediCal and assist these patients in applying for MediCal.

HCSA has recognized the need to improve procedures and to improve the billing system so that MediCal revenues may be increased. HCSA created a MH/AD (Mental Health/Alcohol Drug) task force which examined various billing and liability procedures in County-operated services. Several of MH/AD's recommendations were directly related to increased MediCal collections.

Among MH/AD's recommendations were the following:

- 1) that a monthly collection report be prepared showing P.O.E. label collection by service site
- 2) that patient service technicians (PST) be assigned to take MediCal applications at service sites.

Hence, HCSA addressed the two general ways in which MediCal revenues could be increased. However, the collection of MediCal revenues is hindered by several factors:

- 1) The present billing system can not identify all MediCal patients who received service in a given period of time. A list of such patients is necessary to receive MediCal reimbursement from the State. A data processing list is generated but it must be manually adjusted which is a time-consuming task. Even if a new billing system is acquired for Mental Health, it would be several years before it would be fully operational. Hence, we expect the the awkward manual procedures will continue for several years.



- 2) Because of the low number of patient services technicians available to Mental Health (one in the entire Southern Region, two at Highland Hospital in emergency and in-patient), they have a limited impact.

The underutilization of Short-Doyle MediCal for fiscal year, 1974-75 is \$354,000. It is estimated that the underutilization for fiscal year, 1975-76 will be \$640,000 (figures supplied by HCSA). The following analysis shows that during the fiscal year 1974-75, County-operated Mental Health facilities served many patients eligible for MediCal.

If the Mental Health Service had identified patients eligible for MediCal, had assisted these patients in applying for MediCal, and had subsequently obtained P.O.E. labels, an additional \$354,000 in MediCal revenues could have been collected. To clarify, these revenues could have been collected without serving additional patients. Furthermore, if increased efforts had been made earlier in fiscal year 1975-76, a large portion of the \$640,000 MediCal underutilization could have been collected.

Estimated MediCal Dollars Lost

Methodology Used

1. General Approach

From a sample of billing records at Special Billing, we determined the following:

- a) 41 percent of the patients with \$0 - \$60 annual UMDAP liability are not on MediCal
- b) 31 percent of the patients with \$0 annual UMDAP liability are not on MediCal.



If we use the more conservative figure of 31 percent, we still must consider that not all zero liability patients are eligible for MediCal. Through interviews with persons knowledgeable of MediCal eligibility, we determined that approximately one-half of zero liability patients would be MediCal eligible. Therefore, the following formula will calculate an estimate of the number of MediCal dollars lost because County-operated facilities rendered services to patients who were eligible for MediCal but were not on MediCal:

31 percent x $\frac{1}{2}$ x number of Short-Doyle units of service rendered by County-operated sites x average MediCal dollars reimbursement per unit of service

$$31 \text{ percent } x \frac{1}{2} x 63,000 x \$87 = \$849,555$$

Therefore, if there had been no limit on this County's MediCal appropriation, \$849,555 more could have been collected. However, as forementioned, HCSA - Finance estimates that the underutilization of this County's MediCal appropriation for 1974-75 is \$354,364. Therefore, the maximum additional MediCal dollars that were collectable is \$354,364.

Note: This underutilization may be higher if the State disallows certain costs. If so, the amount of dollars forfeited will also be higher.

2. Specific Approach

a) Sample of billing records -

There were approximately 3000 active cases as of September, 1975 (figure supplied by Mental Health). At Special Billing "blue cards" are filed by patient number. There is no separation of active and inactive cases. For purposes of this section, we define client population as the last 6000 blue cards, dated September 30, 1975 and previous. We selected a sample from this population.

For 98 percent confidence (2 percent error) sample size should be 200. Examine every thirtieth card (6000/200) for the following:

- 1) Is the annual liability between \$0 - \$60?
- 2) If yes, is client on MediCal?

Why 6000 cards were selected as sample size: we did not wish to examine old cards as many of these clients are probably no longer active. Because inactive and active cards are filed together, we believed that a sample from the latest 6000 cards would include many active cases. It would also include cases no longer active but which had been active during 1974-75.

- b) Number of Short-Doyle units of service rendered by County-operated sites and average MediCal dollars reimbursable per unit of service were obtained from the CR/DC report. This report is prepared by HCSA - Finance and submitted to the State for Short-Doyle and MediCal reimbursement. We excluded units of service and cost per unit rendered by Highland-Inpatient because we felt these figures might skew our calculations upward.
- c) We interviewed patient service technicians and other Agency personnel. All agreed that approximately one-half of zero liability patients are MediCal eligible. We also noted that Mental Health had previously used a 50 percent eligibility rate in a study which they prepared.



In order to receive MediCal benefits, a patient must file an application with the Social Services Agency. The patient services technician helps patients file an application. We interviewed persons in several other counties. Counties which had rather good MediCal collections attributed this to good linkages between Mental Health and Social Services. Better linkage with the Social Services Agency would also alleviate some of the present difficulties in obtaining P.O.E. labels. If a MediCal patient forgets to bring in a label, HCSA may order it from Social Services. Often there is a considerable backlog of labels ordered.

The Mental Health Administration has pursued the policy of using the Short-Doyle Medi-Cal appropriation largely for County-operated services. This is explained more fully in the next section entitled "SUPPORT". If Mental Health Administration wishes to continue this policy, action should be taken to maximize use of the Short-Doyle Medi-Cal appropriation in County-operated services. HCSA and Mental Health Administration should consider the use of more patient services technicians and better linkage with the Social Services Agency.



WE CONCLUDE that contracted services do not have sufficient incentives to collect Short-Doyle MediCal monies.

WE RECOMMEND that the Board of Supervisors direct the County Administrator's Office to investigate the possibility of reimbursing contracted services for Short-Doyle MediCal monies in advance of payment of such monies from the State to the County.

WE CONCLUDE that contracted services are not rigorously monitored regarding their efforts to pursue revenues.

WE RECOMMEND that the Mental Health Administration rigorously monitor contracted services regarding their efforts to pursue revenues.

SUPPORT:

Chart II on page 38 shows a comparison of Short-Doyle MediCal and patient fees revenues between County-operated and contracted Mental Health Services in six major California counties including Alameda County. Chart III on page 39 shows the average collection rate of the other five counties.

In Alameda County, mental health contactors eligible to collect Short-Doyle MediCal are collecting at the average of the other five counties.

However, a difficulty is that so few contractors are eligible to collect Short-Doyle MediCal. Only 25 percent of Alameda County Mental Service contractors are eligible to collect such monies. The ratio of Short-Doyle MediCal contractors gross budget to County-operated gross budget is 7 percent. Note that this percentage is generally far greater in the other five Counties. Alameda County does not provide incentives for contractors to collect MediCal monies via Short-Doyle. This is further explained later in this section.



Contracted services may collect MediCal monies either through the "Blues" or through Short-Doyle. If Medi-Cal is collected via the "Blues" the contracted service files his claim directly with Blue Cross. If MediCal is collect via Short-Doyle, the contracted service files his claim with the County. The State appropriates each County a MediCal allotment. This appropriation applies only to Short-Doyle claims. Mental Health Administration in this County has not encouraged contract services to become MediCal eligible via the Short-Doyle MediCal reimbursement method. Mental Health Administration sites several reasons why it is to the contracted services' disadvantage and to the County's disadvantage for contracted services to apply for MediCal monies via Short-Doyle.

These reasons include the following:

- 1) Contracted services experience a delay in receiving monies when claiming MediCal via Short-Doyle. Alameda County reimburses contracted services immediately upon claim for regular Short-Doyle monies. However, due to a County Counsel ruling, contracted services are not reimbursed for MediCal monies until receipt of such monies from the State to the County. For most billings this process takes two to four months. In the case of the June billings, reimbursement takes up to one year. Hence, contracted services, depending on MediCal monies, may experience a cash flow problem if they claim MediCal monies via the Short-Doyle method.
- 2) Open-ended contracts can not be written. When a contract is approved by the Board of Supervisors, it indicates the maximum dollar amount of MediCal revenues which that service may be reimbursed. In one instance a contracted service was able to collect P.O.E. labels for revenues substantially greater than the amount indicated in the contract. However, all dollars over the contract limit became revenue for Mental Health and were used to offset the deficit. This procedure is State policy and it appears to limit a contractor's incentive to generate MediCal revenues.

- 3) The State allows each county to claim up to the maximum dollar amount of MediCal allowed in that County's appropriation. The State does not deduct "Blues" claims from a County's appropriation. Therefore, if more contracted services apply for MediCal via the "Blues", this allows County-operated services a greater proportion of the MediCal appropriation.

Our interviews indicate that some persons in Mental Health Administration may resist the procedure of advancing payment to contracted services believing that it could create problems for the County. The County acts as a loan agent when advancing these monies. Considering the small amount of monies, it is doubtful that interest lost on MediCal monies forwarded could create a serious cash flow problem for this County. For example, approximately \$250,000 was claimed by contracted services during fiscal year 1974-75 via Short-Doyle. With advance payment, most of this money would have been advanced for approximately two to four months. Interest lost would have been several thousand dollars ($\$250,000 @ 8\% @ 1/3 \text{ year} = \$6,660$). This figure could increase somewhat if more contractors began claiming via Short-Doyle. On the other hand, increased motivation to collect MediCal dollars could have offset this cost to the County in additional services available to clients because contracted services were pursuing MediCal revenues.

Note from Chart III on page 39, that contractors, included in Chart II data, collect a much lower percentage of patient fees than do contractors in other Counties.

In Chart IV on page 40, we present a comparison of collections for Alameda County contractors as compared to the County-wide average. Only contractors eligible to collect MediCal revenues are included on



on Chart IV. Percent of revenues from MediCal and patient fees are presented. In comparing the collection rate of the various contractors, several items should be kept in mind:

- 1) Each service modality has unique problems in collecting revenues. For example, crisis services often offer short-term treatment. Because of the turnover of the patients seen, it is sometimes difficult to obtain P.O.E. labels.
- 2) State Department of Health personnel suggested to us that when patient fees are low, it would be expected that MediCal revenues are high. This is because low patient fees collection may suggest that a relatively poor population is being served. Hence, more patients would be eligible for MediCal. Therefore, in Alameda County, for those contractors who serve largely a poor population, we would expect lower collection of patient fees and higher collection of MediCal revenues as compared to other services. This often appears to be so.

Notice in Chart IV, that several of the contractors are significantly below the County-wide average for percent of MediCal collections and patient fees collections. Personnel from counties with good revenue collection suggested to us that revenues collected by contracted services can be increased by stepping up the monitoring of those services. Presently in Alameda County, contractors are not monitored rigorously for pursuit of revenues.



WE CONCLUDE that HCSA and the Mental Health Administration did not adequately pursue revenue from private insurance. If the Mental Health Service had been able to collect at the average rate of other California Counties in private insurance, the additional revenues would have been \$237,800 in fiscal year 1974-75.

WE RECOMMEND that the Mental Health Service use a standardized insurance claim form which can be completed at the treatment facility rather than depending on the patient to bring in a claim form from his insurance company, as is presently done.

SUPPORT:

The State Office of the Auditor General recommended in its management review of the California Community Mental Health System (dated February, 1975) the use of a standardized claim form. This report sited Orange County as an example of increased revenue generation because of use of a standardized form. Per the forementioned report, patient insurance revenue increased from 3.4 percent of adjusted gross costs in fiscal year 1972-73 to 4.6 percent in fiscal year 1973-74. Alameda County collected only .7 percent of its gross program in insurance revenue during 1974-75. The State-wide average for insurance revenue collection is 2.7 percent of gross program. (Refer to Chart 1 on page

Calculation: $(2.7 - .7) = 2\%$

$$2\% \times 11,887,883 = \$237,758 \text{ which is approximately } \$237,800$$

HCSA personnel have sited a difficulty in collecting private insurance monies: To receive employee health benefits an employee must inform his employer that he received service from a mental health treatment facility. Some employees may not wish to do this. We agree that this is a difficulty. However, other County Mental Health Services are



faced with this same problem and yet the average State-wide collection rate is higher than the Alameda Mental Health Service average.



WE CONCLUDE that the UMDAP system presents numerous problems. It is sometimes difficult to implement and it sometimes has effects upon treatment. Some of these problems are due to County procedures, or lack thereof. Other problems are basic to UMDAP and would require a change by the State in the mandated procedure.

WE RECOMMEND that the Mental Health Administration make its UMDAP explanation brochure available to County-operated and contracted services in any languages needed.

WE RECOMMEND that the Mental Health Administration increase UMDAP training programs and make this service available to County-operated and contracted services.

WE RECOMMEND that the Mental Health Administration redefine the UMDAP appeals procedure and make all services aware of that procedure so that appeals are reviewed in the same manner throughout the County.

WE RECOMMEND that HCSA efforts and Mental Health Administration efforts related to the previous three recommendations continue in a timely fashion.

WE RECOMMEND that Health Care Services Agency express cost-of-service rates by various types of service rendered (as opposed to one cost per modality as presently calculated) to make UMDAP more equitable. A nominal fee should be set..for first visits in short-term services.

WE RECOMMEND that the Board of Supervisors direct the County Administrator's Office to investigate possible State violation in present cost-of-service rates approved by the Board. These rates are submitted by HCSA for Board approval. If investigation so indicates, rates should be adjusted.

WE RECOMMEND that the Board of Supervisors lobby the State for improvements in UMDAP. We suggest that major problems with fees set for 24 hour residential services be corrected and that a monthly or per session liability be considered. A monthly or per session liability would make UMDAP more workable in short-term services.

SUPPORT:

UMDAP refers to the Uniform Method to Determine ability to Pay and is a State-mandated procedure for determining a patient's ability to pay for Short-Doyle services. UMDAP is calculated as a yearly family liability and it is based upon family size, income, assets and allowable deductions. The yearly liability is divided into equal monthly charges to the patient.

During our overview process, many persons expressed the opinion that UMDAP is difficult to implement and that it sometimes has effects upon treatment. Our findings based upon interviews and responses in staff questionnaires support that opinion.

Responses from our staff questionnaires indicate that clerks, clinicians, and clients often don't understand UMDAP. Responses also indicate that clerks and clinicians perceive a lack of appropriate UMDAP brochures and forms. Clients often complain and often they are reluctant to cooperate. Refer to the appendix which shows relevant questions asked on the staff surveys and responses.

In interviews with various persons throughout this County responsible for determining UMDAP, we noted that different criteria are sometimes used in the calculation of the UMDAP fee. In response to the UMDAP questionnaire administered by Mental Health Administration, many questions were raised by clerks regarding how to compute UMDAP in circumstances which don't follow the book exactly. It appears that each person is making a determination in many instances based upon his/her interpretation of UMDAP procedures.

State policy states that the client has the right to review of any decision relating to his financial ability and that client appeals follow the normal claim of authority up to the State Department of Health. In the Clerical Survey, the appeals procedure was defined differently from clerk to clerk. Our interviews support this. There is no County-wide appeals procedure which all sites follow. The person in Mental Health Administration responsible for receiving appeals reviewed only



ten in the past year. She confirmed that the appeals are not getting to her. Each service has it's own appeals procedure - generally not formalized. Hence, clients do not get an equal, consistent right to appeal throughout the County!

During our overview process, personnel in crisis services most often expressed concern that UMDAP adversely effects treatment. Crisis services more often deal with short-term treatment than other modalities. The UMDAP method is sometimes difficult to implement in short-term services. This difficulty can best be illustrated by an example:

A parent brings his child to a children's service. The family liability is determined to \$150 per year while the cost of service is \$49 per visit. If cost-of-service is less than the annual liability that is the amount which this family owes. If this child is seen three times the family pays \$147 ($3 \times \49). If the child is seen four or more times, the family pays \$150. In many instances the cost-of-service is higher than the charge for equivalent services in the private sector. If the clinician could determine how many visits this child should have, it would be easy to determine if the family should use the Short-Doyle facility or go to the private sector. Obviously it is not always easy to make this determination. If treatment is long-term it is easy to decide that the family in this example can benefit financially from using Short-Doyle services.

It was suggested to us in our overview that many clinicians evade the effects of UMDAP upon short-term service by not opening a chart while continuing to see a patient. The staff questionnaires confirm that this occurs: Six percent of the clinicians answered that cost-of-service is so high that sometimes they don't open a chart and continue to see the client. Sixteen percent of the clerical persons answered that clinicians sometimes ask them to not open a chart on a client.



As indicated in the Appendix, 26 percent of clinicians in Crisis Services agreed that UMDAP causes clients to stay in treatment longer than necessary to get their money's worth, and that it discourages clinicians from aiming toward short-term treatment.

The Report of the State Auditor General to the Joint Legislative Audit committee, dated February, 1975, stated the following:

The UMDAP System is not conducive to effective revenue collection of patient fees and it is not a suitable tool for evaluating liability for short-term treatment.

Personnel at Lincoln Child Center sited a glaring example of the effects of UMDAP upon 24-hour residential treatment. When a family's liability is calculated using UMDAP, it is frequently cheaper for a family to keep a child at Lincoln than to keep him at home. For example, a \$60 per year liability is certainly cheaper than supporting a child in the home. This has adverse effects upon returning the child to his family.

Some clinicians expressed concern that UMDAP was scaring patients away when they heard the cost-of-service that they would be billed unless they met their annual liability. Furthermore, some clinicians questioned even calculating the UMDAP liability considering that in the past for County-operated services, patients were billed months late, if ever.

The cost-of-service rates represent another problem in the implementation of UMDAP. There are two cost-of-service rates calculated in the County. One is the rates reported in the CR/DC report which is submitted to the State for Short-Doyle and MediCal reimbursement. The other is



the Board of Supervisor approved rates submitted by HCSA. These latter rates are charged to the patient or his insurance company. Note: The patient pays either his UMDAP liability or the Board rate for cost-of service, whichever is less. State personnel called to our attention the fact that it is illegal to charge Short-Doyle and MediCal at different rates than those charged to the general public. Our analysis indicates that the Board rates are set at far less than cost. Besides being in conflict with the law, this County is losing money on full-pay and privately insured patients by charging less than actual cost.

Cost-of-service in this County is calculated by modality. A patient may receive only ten minutes of service for a medication refill or he may receive hours of a therapist's time; in either instance the cost-of service is the same amount for purposes of billing a patient. We believe that cost-of-services relative to types of services received would be more equitable. There is a certain amount of resistance by some services and some therapists to UMDAP. A sliding scale relative to type of service rendered would make UMDAP more acceptable to many persons. This would also make UMDAP more workable in short-term services. Presently if a patient calls up for information, this is considered consultation, education, or information service (CEI) and there is no charge. However, if the patient comes in for this service, he/she is billed for one visit. A nominal fee for first visit in short-term services would encourage persons to use the service. At that time, it could be determined if it is to that patient's financial benefit to continue using a Short-Doyle service, if indeed more visits are needed.



Presently some of the sites record the first visit as a CEI. If a nominal fee was charged for first visits in short-term services, more persons would be charged and this might offset decreased revenue due to a lower rate for this type of service.

Another way in which UMDAP would be more workable would be to change this State-mandated procedure to a monthly or per session liability basis; 40 percent of the clinicians who answered our survey agreed with this. Presently, it is often difficult to determine how much the client will be paying for service over the year. A monthly or per session liability would allow the client to more readily determine how much service is going to cost him. Liability determined in this fashion would also make UMDAP more workable in short-term treatment.

Some suggested that the revenues collected from patient fees are so insignificant that no attempt should be made to charge patients. If the Mental Health Service collected the State-wide average in patient fees, \$249,700 would have been collected in 1974-75 (In fact, only \$47,600 was collected). Considering the present fiscal difficulties of Mental Health, the value of collecting patient fees cannot be ignored.



WE CONCLUDE that the present billing and accounts receivable system used by HCSA (Special Billing) adversely affect clients.

WE RECOMMEND that HCSA efforts to implement a new billing and accounts receivable system continue with increased input from the Mental Health Administration.

SUPPORT:

Our analysis indicates that the current HCSA billing procedures sometimes have a negative effect upon the treatment of a patient. As late as last November, some patients were being billed one year after service. Clinicians sited examples where the delayed receipt of a bill had severely upset some patients. (Refer to the appendix for relevant questions asked on staff surveys and corresponding responses). It is interesting to compare County-operated staff responses to contracted staff responses. Contracted services perform their own billing functions.

As compared to County-operated services, it appears that contracted services generally have a more understandable bill, that billing and/or UMDAP less often affect a client's condition, and that clients complain less about billing and UMDAP.

40 percent of the clinicians believe that the delays experienced by Special Billing in getting bills mailed have adversely affected clients.



WE CONCLUDE that County-operated and contracted services, and HCSA-Special Billing are in conflict with State policy with respect to certain billing and collection procedures.

WE RECOMMEND that HCSA, the Mental Health Administration, and chiefs of contracted services implement procedures for the following:

- Follow-up procedures for uncollected clients' bills. Follow-up should include consultation with a client's therapist.
- Redetermination of UMDAP liability as frequently as required by State policy.
- Discussion of unpaid liability with the client at the time of his discharge.

WE RECOMMEND that the Mental Health Administration have input into decisions made by HCSA - Finance regarding Mental Health to insure that all procedures implemented comply with State policy regarding Community Mental Health Services.

SUPPORT:

A comparison of procedures followed within this County to State policy reveals instances where local procedures are in conflict with State policy. The following quotes on State policy are taken from "Uniform Billing Guidelines and Procedures for Community Mental Health Services" published by the State of California Department of Health and Welfare Agency, dated July, 1974. These guidelines are considered "minimum acceptable standards."

STATE POLICY:

The successive steps in billing a client or responsible person are outlined. (The time between billings is a standard and must be closely followed).

1. Initial billing at determined monthly payment to be sent during the calendar month following the month that services were provided.



2. Second billing for total accumulated monthly payments to be sent during the calendar month following the initial billing month.
3. No response prior to the calendar month following the second billing suggests consultation with the therapist involved in the treatment as to the client's mental or physical condition which could affect ability to pay. In the case where the responsible person is other than the client, determine from the therapist if there are any known reasons why collection efforts should not be continued. The therapist may elect to discuss the matter with the client or responsible person.

HCSA - Special Billing - Procedure

In the past, Special Billing, which prepares bills for County-operated services, was at least eight months behind in preparation and mailing of clients' bills. Due to the doubling of staff, for this purpose, this situation has improved and most bills are being prepared in a more timely fashion.

However, no follow-up of unpaid bills is done. In the past, Special Billing referred some unpaid Mental Health bills to Central Collections. Central Collections is the County department responsible for instigating collection procedures. Therapists were not consulted to determine any repercussions with respect to the client's condition. Therefore, these collection efforts were in direct conflict with State policy.

In an effort to correct this situation, Special Billing determined that no follow-up should be done on unpaid Mental Health billings. At this time, no follow-up has been done on unpaid bills for at least one year.

The foregoing is an example of a decision made by HCSA which was in direct conflict with State-mandated policy. This decision was made without input from the Local Mental Health Director or her representative.



The State considers it the responsibility of the local Director that the local mental health program comply with State policy. Mental Health Administration should have input into decisions made by HCSA - Finance (which includes Special Billing) to insure that procedures implemented comply with State policy regarding Community Mental Health Programs.

STATE POLICY

At time of discharge, all accrued changes, as established by UMDAP, should be discussed with the client to insure that a clear understanding exists as related to the persons financial responsibility.

LOCAL PROCEDURES

Our staff questionnaires indicates that 70 percent of the clerks in County-operated services and 20 percent in contracted services do not follow proper state policy, with respect to this procedure.

STATE POLICY

Ability determination will be made on the first visit if possible. Redetermination of ability shall be made at least annually or at any time changes occur in family size, income, liquid assets, or allowable expenses.

LOCAL PROCEDURES

Our staff questionnaires indicate that at 87 percent of the County-operated services, more than 50 percent of the clerks follow this procedure. However, this is true of only 25 percent of the contracted services.

Chart I

Alameda County

Comparison of Revenues to Percent of
Gross Program

	<u>Alameda County</u>	<u>State-Wide Average</u>
Grants	5.1%	5.1%
Patient Fees	.4%	2.1%
Patient Insurance	.7%	2.7%
Medi-Cal	19.1%	23.1%
MediCare	.6%	1.3%
Other	2.6%	
Federal Funds	2.5%	4.6% (Other & Fed. Funds)
Total Revenue Percent of Gross	31.0	38.9
Gross Program	\$11,887,883	

SOURCE: State Department of Health

Chart II

A Comparison of Revenues in Other Counties to Alameda County (Includes only those programs eligible to collect Short-Doyle Medi-Cal)

<u>County</u>	<u>Budget Gross Program</u>	<u>Patient Fees Revenue</u>	<u>Percent of Gross</u>	<u>Medi-Cal Revenue</u>	<u>Percent of Gross</u>	<u>*Percent of Con- tractor Gross Budget to County-Operated Gross Budget</u>
Alameda						
County-operated	\$ 9,193,178	\$ 39,322	.4%	\$2,352,364	25.6%	
Contracted	\$ 671,134	\$ 3,253	.5%	\$ 251,747	37.5%	7%
San Francisco						
County-operated	\$12,472,713	\$ 34,202	.27%	\$1,623,600	13.0%	
Contracted	\$ 6,952,385	\$166,831	2.4%	\$3,633,704	52.3%	56%
Santa Clara						
County-Operated	\$ 8,589,882	\$235,439	2.7%	\$1,953,323	22.7%	
Contracted	\$ 3,259,927	\$ 98,852	3.0%	\$1,337,891	41.0%	38%
Los Angles						
County-operated	\$13,392,073	\$ 79,353	.6%	\$ 744,352	5.6%	
Contracted	\$15,506,260	\$445,144	2.9%	\$5,438,789	35.0%	116%
San Diego						
County-operated	\$10,332,345	\$280,595	2.7%	\$1,968,953	19.0%	
Contracted	\$ 1,265,423	\$ 64,646	5.1%	\$ 402,508	31.8	12%
Orange						
County-operated	\$ 7,382,145	\$133,388	1.8%	\$2,296,408	31.1	
Contracted	\$ 1,824,804	\$ 77,639	4.3%	\$ 559,885	30.7	25%

SOURCE: State Department of Health, CR/DC data for fiscal year 1974-75

* Includes only contractors eligible to collect Short-Doyle Medi-Cal

Chart III

Comparison of Average Percent
of Collections Based Upon Chart II

<u>Other Five Counties</u>	<u>Average Percent of Patient Fees</u>	<u>Average Percent of MediCal Revenues</u>
County-Operated	1.6%	18.3%
Contractor	3.5%	38.2%
<u>Alameda County</u>		
County-Operated	.4%	25.6%
*Contractor	.5%	36.8%

* Note: Alameda County contractors eligible to collect Short-Doyle Medi-Cal are collecting Medi-Cal at about the average rate of other contractors. However, a vast number of this County's Mental Health contractors are not eligible to collect Short-Doyle Medi-Cal. This pulls the County-wide average down to 19.1%.

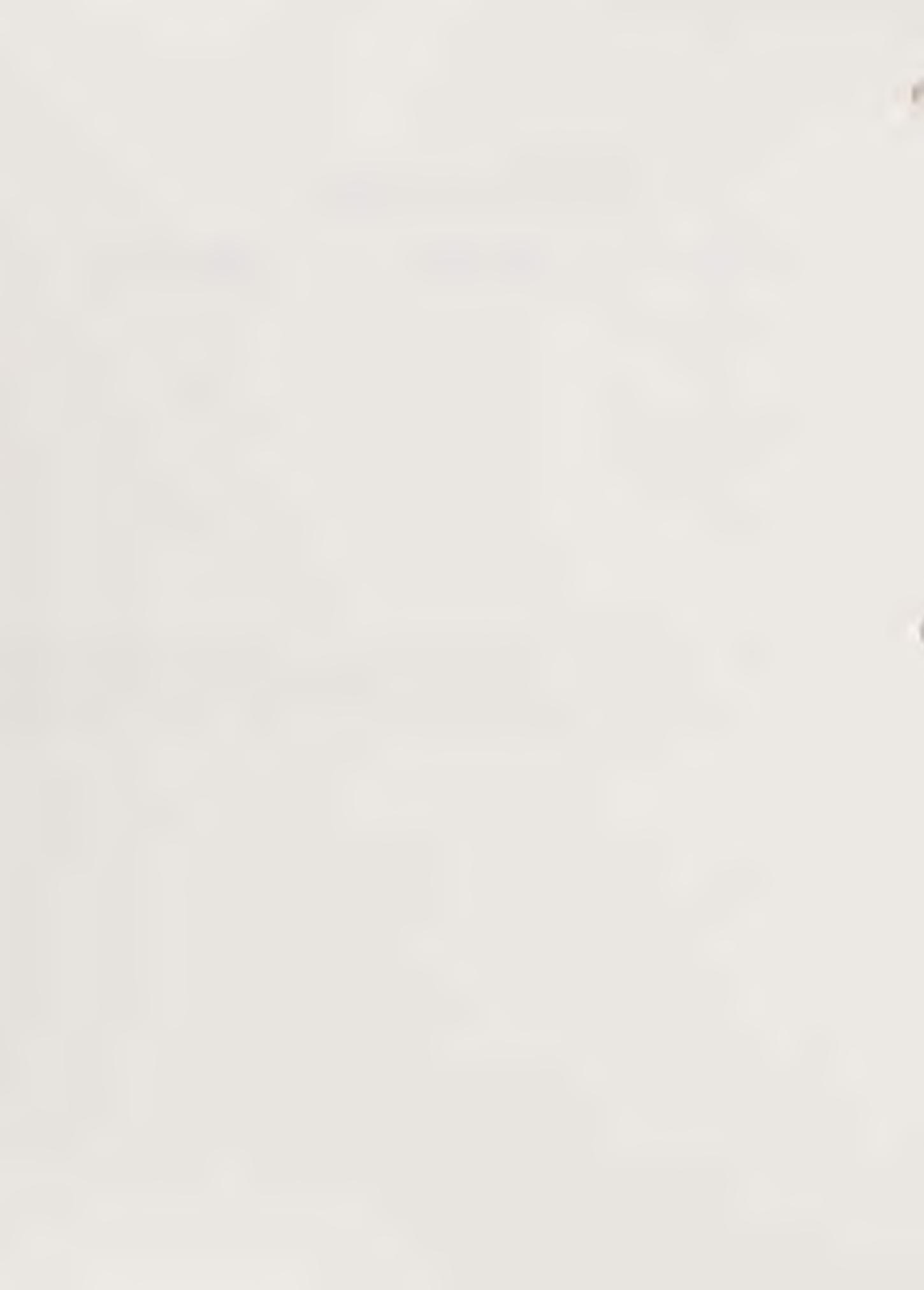


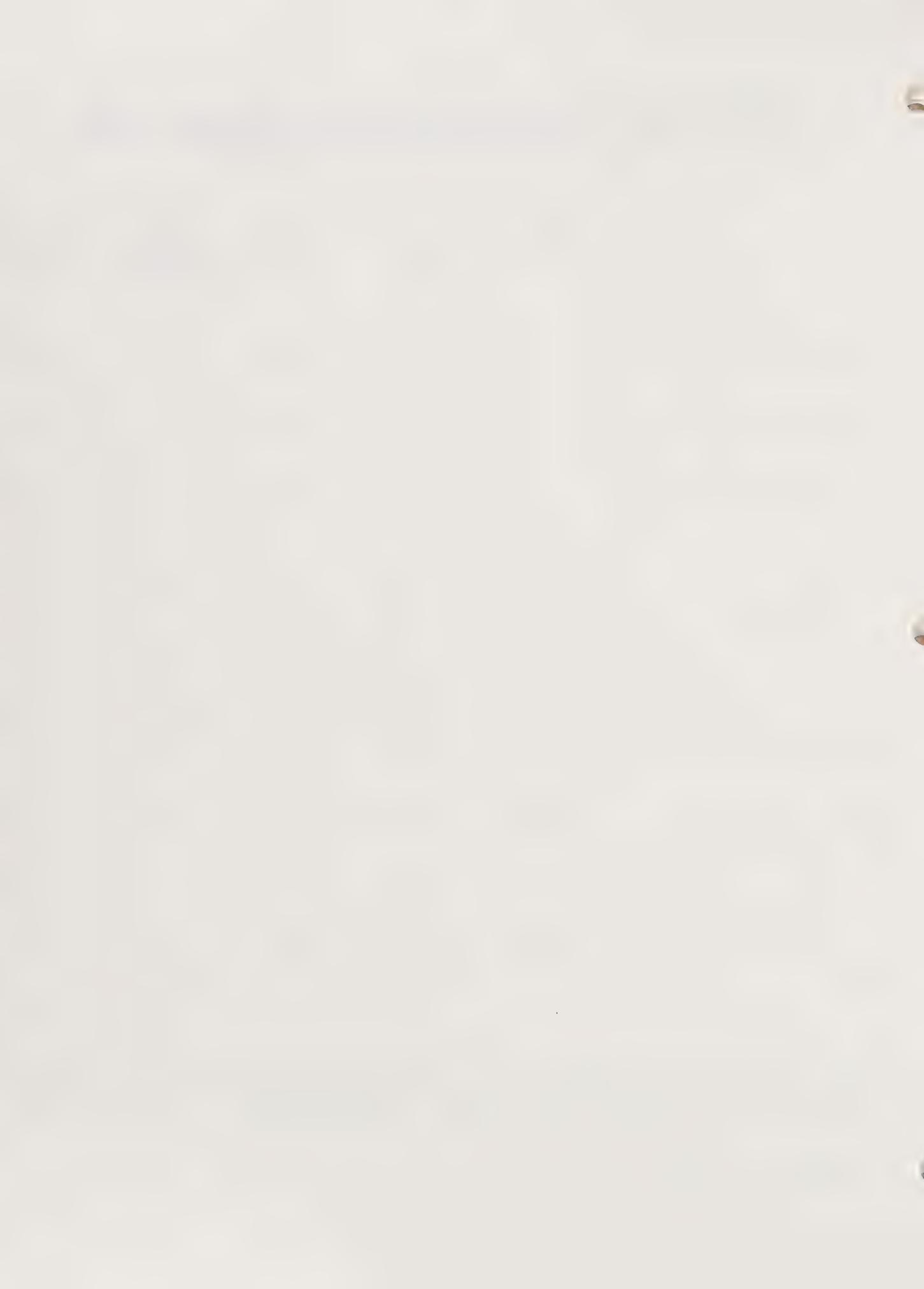
Chart IV

Comparison of Alameda County Contractors Rate of Medi-Cal and Patient Fees Collection to County-Wide Average (Includes only those contractors Eligible to Collect Medi-Cal (Via Short-Doyle))

	Gross Program Cost	Medi-Cal Revenues	Percent of Gross Program	Patient Fees Revenues	Percent of Gross Program
County-wide Average			19.1%		.4%
Average of County-operated Crisis Services			17.3%		1.1%
Average of County-operated Rehab Services			44.4%		.3%
Average of County-operated Day Treatment Services			41.3%		.08%
Berkeley					
Crisis	\$ 67,342	\$ 8,714	12.9%	\$ 133	.2%
Partial Day	\$103,132	\$ 51,915	50.3%	0	0
Rehab	\$ 36,402	\$ 4,774	13.1%	0	0
East Bay Activity Center	\$ 90,768	\$ 36,240	39.9%	\$2,099	2.3%
**East Oakland Health Alliance	\$119,705	\$ 10,725	8.9%	\$ 987	.8%
Gladman Partial Day	\$160,000	\$115,975	72.5%	\$ 34	.02%
West Oakland Health Center					
Crisis	\$ 49,825	\$ 12,872	25.8%	0	0
Out Patient	\$ 43,960	\$ 10,532	24.0%	0	0
TOTAL	\$671,134	\$251,747		\$3,253	
		37.5%		0.5%	

** East Oakland Health Alliance contract includes \$45,936 for Consultation, Education, and Information (CEI). These costs are not billable, hence, not Medi-Cal reimbursable. Therefore, if we express Medi-Cal revenues and patient fees as a percent of direct treatment cost the percents are 14.5% and 1.3% respectively.

SOURCE: CR/DC report for fiscal year 1974-75.

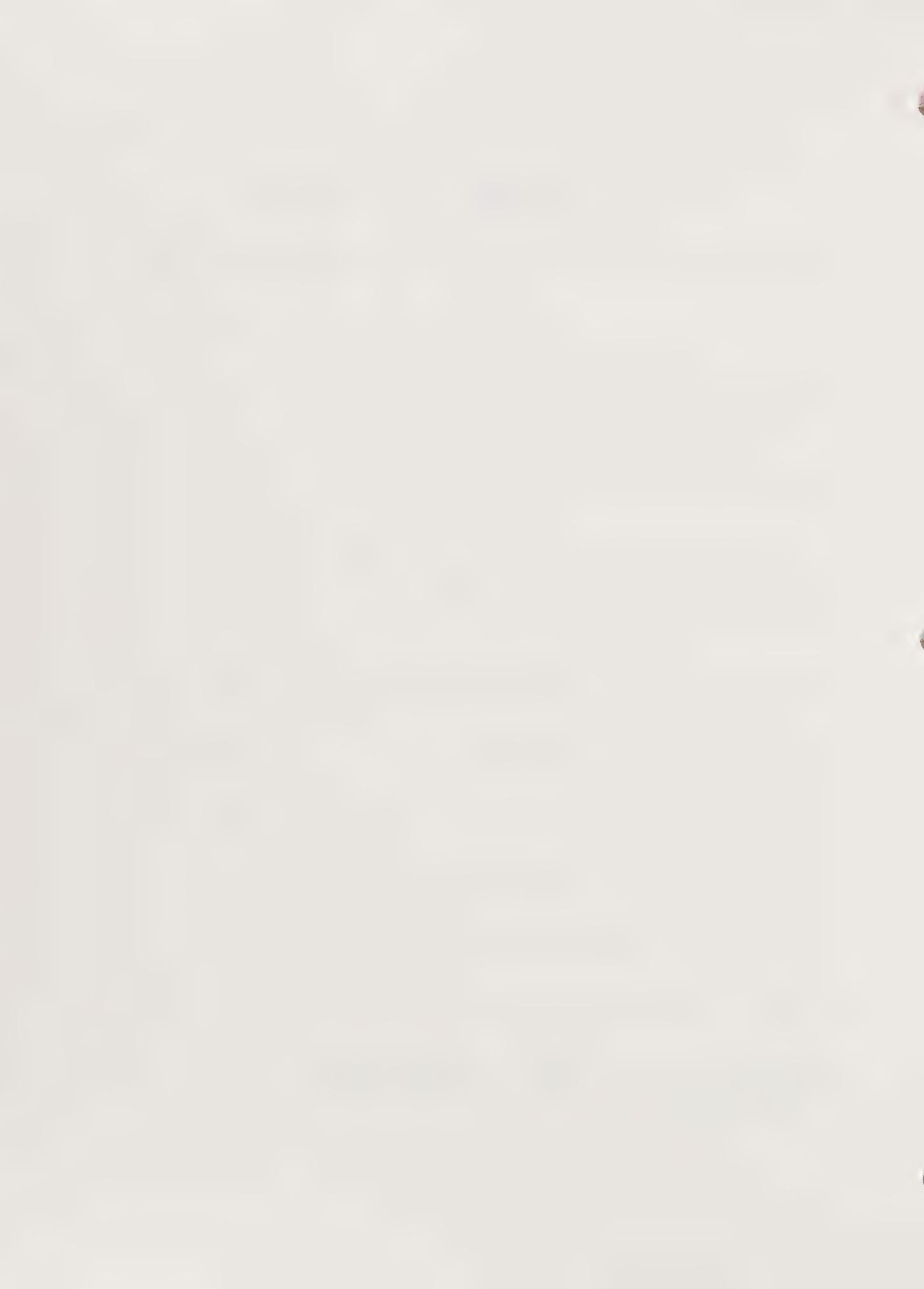


Appendix

Billing and Liability Issue Relevant Staff Responses on Questionnaires

Clinical - relevant questions and responses include the following:

	<u>Yes</u>
● Do persons who complete UMDAP have problems with UMDAP?	40%
● UMDAP explanation given to client is unclear.	49%
● Clerks and therapists often don't understand UMDAP?	37%
● UMDAP materials not printed in language needed.	23%
● Clients often don't understand UMDAP.	77%
● Clients often unwilling to cooperate.	25%
● Clinicians expected to be involved in determination of financial liability in anyway?	35%
● Problems in UMDAP liability referred to clinicians (usually or sometimes).	67%
● UMDAP is equitable.	17%
● Cost-of-service is higher than private sector.	19%
● UMDAP, combined with cost-of-service, results in serving only the economically disadvantaged.	22%
● Cost-of-service should be divided into various types of service rendered.	29%
● Ability to pay should be calculated on a monthly or per session basis.	40%
● At least the principle UMDAP uses is good and should be kept, since paying is usually a positive part of therapy.	33%



● Cost-of-service is so high - sometimes don't open a chart.	6%
● Liabilities are so low - seldom any effect on treatment.	18%
*● Establishing an annual liability often causes clients to stay in treatment longer than necessary.	10%
*● Establishing an annual liability discourages clinicians from aiming toward short-term treatment.	16%

* For each of these questions 26% of clinicians in Crisis Service agreed. Considering that problems of UMDAP as related to short-term treatment were most often expressed during our overview by Crisis personnel, this is not surprising.

	<u>Co-op</u>	<u>Ctr</u>
Clients complain about UMDAP		
Occasionally	47.3%	38.3%
Often	23.2%	3.7%
	70.5%	42.0%

Chiefs of Service - Relevant questions and responses include the following:

	<u>Yes</u>	
	<u>Co-op</u>	<u>Ctr</u>
Do you believe that all or most clients can understand the bill which they receive?	31.6%	93.4%
Do you believe that billing and/or liability (including UMDAP) procedures have played a significant part in some of your program's clients not improving or actually worsening the condition in treatment?		
Yes, this has happened with at least several of my clients with the past year.	16.7%	6.7%
Yes, this has happened with at least one of my clients within the past year.	33.3%	20.0%
No, I don't believe that this has happened.	50.0%	73.3%

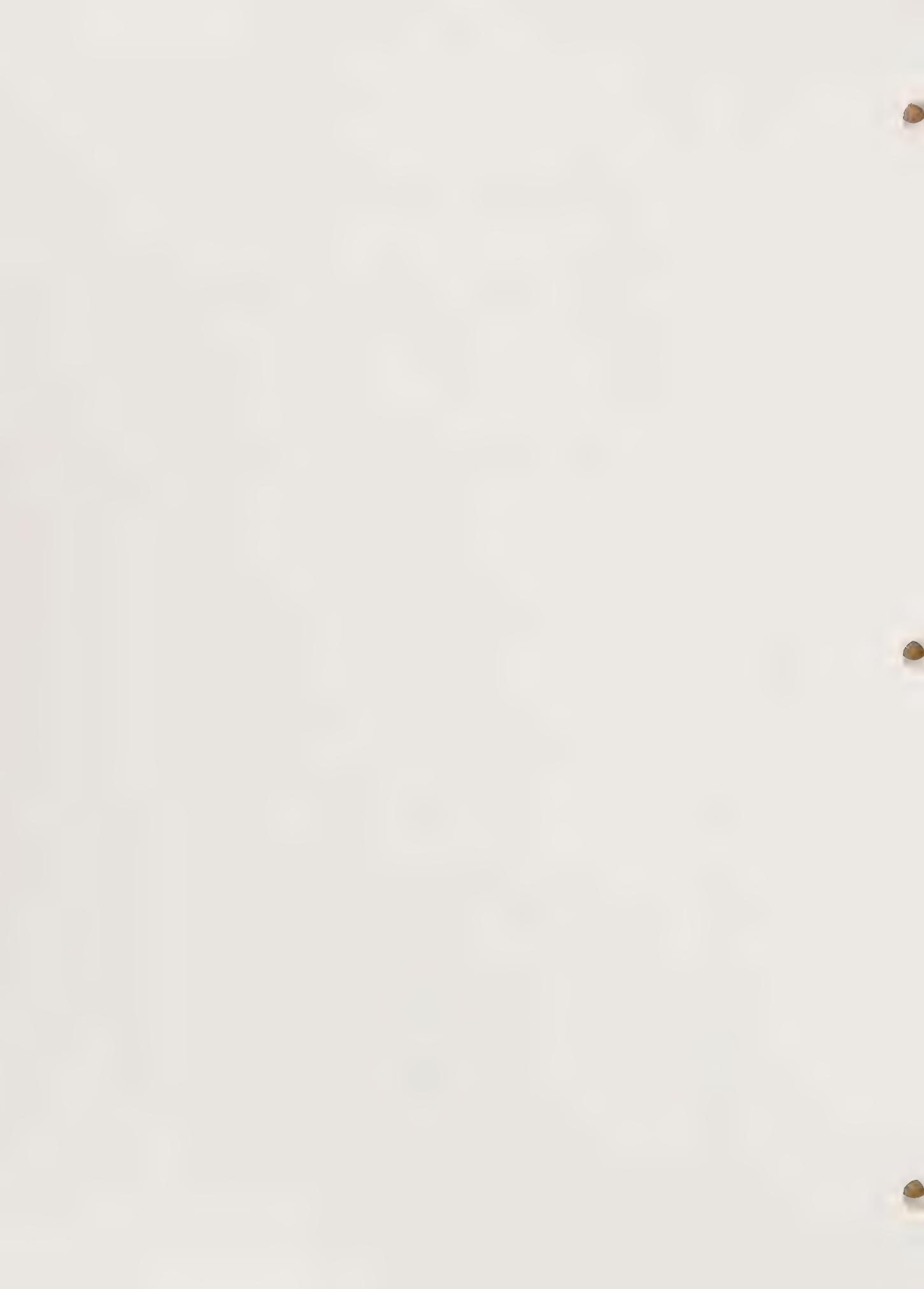


CLERICAL

Relevant questions and responses include the following:

	Ctr	% who Answered		Total
		Yes	Co-op	
Do you consider UMDAP a part of your job?	100	77	83	
Do you have a brochure to explain UMDAP to clients?	55	70	66	
Does the process of determining financial liability ever present problems for you?	55	80	73	
*Clients are often reluctant to cooperate.	33	69	63	
*Clients often do not understand UMDAP.	67	86	81	
UMDAP brochure unclear.	33	39	38	
I have difficulty with UMDAP.	33	35	34	
UMDAP materials not printed in the language I need.	0	8	6	

*% of those who answered question.



LINKAGES BETWEEN MENTAL HEALTH AND OTHER SERVICES

LINKAGES BETWEEN MENTAL HEALTH AND OTHER SERVICES

Summary of Conclusions and Recommendations

WE CONCLUDE that lack of information, in Mental Health Programs about SSA procedures and priorities results in delays in benefits for the most seriously disabled client population. Opportunities to discuss problems and policies with the local SSA Medical Evaluation Unit have not been exploited by our County Mental Health Services.

WE RECOMMEND that County Mental Health Service should concentrate on facilitating the process of certification for SSI. This effort has been primarily undertaken by the Alameda County Mental Health Association, which may have the effect of reducing Mental Health Service perceptions of the need to be actively involved.

- a) As a long range objective, efforts should continue to effect changes in federally-mandated forms and procedures so that they are more easily used by the mental health client.
- b) As an immediate objective, Rehab units responsible for initiating the process of application should establish regular communication with local SSA units.

WE CONCLUDE that there is a great need for continuing involvement of Rehab personnel with client until the entire application and eligibility process is complete. Our analysis suggests that this sort of continuing involvement is far from the rule in dealing with SSI applications.

WE RECOMMEND that Mental Health Services be responsible for clarification and dissemination of information about the necessary role of staff in the application process for SSI. Further, advocacy and continuing involvement should be made explicitly a part of the job description of all Rehab workers involved in the SSI application process.

WE CONCLUDE that the Southern Region plan for mobile PST's shows that some consideration has been given to the problems faced by mental health clients in dealing with Welfare regulations. However, the lack of such efforts in other parts of the County may have significant effects on MediCal revenues available within the County.

WE RECOMMEND that a program similar to that implemented by South County be developed for North County. This would have to involve enough staff to be able to visit each site frequently. PST responsibilities should include familiarizing all clerical staff of individual units with Welfare regulations, procedures, timetables and office locations.

WE CONCLUDE that the dependence of Mental Health Service on Social Services for MediCal certification makes it imperative that administrative coordination exist. That coordination has been virtually non-existent. This has definite impacts on Mental Health Service ability to perform its own functions efficiently.

WE RECOMMEND that the CAO be responsible for mandating the relationship. The recently-formed Human Services Council may provide one mechanism by which this can be accomplished. Mental Health Services is not now specifically included in the Council. We recommend that it be included in the future. However, the need to mandate coordination at the staff level, as well as among administrators of agencies, remains and must be immediately addressed.

WE CONCLUDE that current contract and administrative policies do not encourage cooperation or mutual appreciation between Rehab and CCSS workers. The present contract structure allows variation in expectations among districts, and underutilizes CCSS staff in areas which are already under-staffed by mental health professionals.

WE RECOMMEND that contracts between Rehab services and CCSS workers should be formulated to ensure that advantage is taken of the professional qualifications of CCSS staff. Our data on staffing patterns indicates that less than half of Rehab staff are professionals. This suggests that staff with professional qualifications, whether Rehab or CCSS workers, should be able to concentrate on therapeutic activities for those clients who will benefit from them.

WE CONCLUDE that a "piecemeal" orientation toward clients presently exists when responsibility for the on-going clinical work with the client is terminated after board and care placements. A concentration on placement, without involvement in treatment, provides no incentive for continued concern with welfare of the client.

WE RECOMMEND that professional staff be encouraged in all cases to continue involvement in the treatment of the client. Responsibility should not be tied to funding sources, or to the delivery of only one isolated service such as residential placement.



WE CONCLUDE that the legal limits of the conservator's authority have not been adequately defined at the staff level. This results in inappropriate demands being made on the conservator's office in cases of difficult patients, or in inadequate responsibility being taken by Mental Health Service workers.

WE RECOMMEND that immediate efforts must be made to clarify the individual responsibilities of conservator and mental health at the staff level. Since these relationships involve not only county staff, but also State CCSS staff, CCSS administration should be included in all administrative communication concerning the conservator.

WE CONCLUDE that mental health units have relied heavily on DR contracts for vocational rehabilitation of clients. This acts to narrow the options for all but the least impaired mental health clients. There have been few prevocational programs initiated by mental health, and these have been primarily due to efforts of individuals, rather than to a commitment to such programs by the Mental Health Agency.

WE RECOMMEND that Mental Health Services should have primary responsibility for initiating prevocational programs for clients. The Southern Region Vocational Program now functioning in Eden District should be used as a possible model for these programs. This program utilizes a number of community resources, and Federal CETA funding in a four-step training process. The County should further explore the availability of alternative funding sources for these programs.

WE CONCLUDE that Alameda County does not presently have the capability to work effectively with police services in a fashion allowing for maximum use of mental health staff in crisis situations.

WE RECOMMEND that the County develop a 24-hour crisis intervention capability service. It is imperative that services be available when the crisis situation occurs. This refers not only to operating hours, but also to location. Response to crisis situations should be made as rapid as possible through decentralization of service capability.

WE CONCLUDE that there are few continuing linkages at either the program or administrative level between local police and mental health units - even though both agencies frequently are concerned with the same clients.

WE RECOMMEND that County Mental Health administration be responsible for informing local police department an ongoing basis about services offered by mental health. Resource manuals should be revised and updated at regular intervals. Staff communication, not presently stressed, should be encouraged in order to anticipate community problems.



WE CONCLUDE that because of the short time of operation of the Criminal Justice Unit at Santa Rita, no recommendations for change should be made at this time. Future planning for CJMHSU indicates that efforts will be made to increase involvement at Santa Rita between mental health and Sheriff's department personnel. Therefore, recommendations for change at the program level would be premature.

The need for adequate facilities for screening and evaluation has been discussed before the Board of Supervisors. This need still exists.

WE CONCLUDE that Mental Health staff are not able to provide an adequate level of treatment services to Juvenile Hall. This has the effect of increasing staff tension, and decreasing the probability that cooperation between the two staffs will be maintained. We further conclude that the primary mental health functions relating to the Juvenile Justice System are:

- 1) handling of crisis in detention setting,
- 2) detection of juveniles with mental health problems at intake points of the Juvenile Justice System (Juvenile Hall),
- 3) screening of referrals for diagnostic evaluation and/or psychotherapy,
- 4) input into decision-making for children acknowledged to have psychological problems as well as anti-social behavior patterns,
- 5) consultation to juvenile institutions,
- 6) diagnostic evaluation,
- 7) therapeutic treatment, and
- 8) community advocacy, prevention, and out-reach.



WE RECOMMEND that a core staff of five personnel be retained as the Probation Guidance Clinic and based at Juvenile Hall with the mandate to perform the first four functions listed in the previous conclusion. We recommend that regular and on-going consultation to the juvenile institutions be discontinued. We further recommend that two staff from the present PGC be re-allocated to Eden Children's Center to provide diagnostic evaluations and psychotherapy on a "charge-back" basis to wards of the Juvenile Court and in the custody of the juvenile institutions. We finally recommend that the remaining three staff members be re-allocated to Tri-City, Valley, and Central Children's Services.

WE CONCLUDE that present policies and divisions of authority and responsibility for placement jeopardize the welfare and minimize the benefit to children who are placed out of their homes by the Juvenile Court for psychological reasons.

WE RECOMMEND that negotiations be scheduled between the Judge of the Juvenile Court, the Chief County Probation Officer, and the Local Mental Health Director. The Director of the Probation Department's Placement Division and a Coordinator of Children's Service should also be included in these negotiations. Issues to be resolved include:

- 1) responsibility for deciding when out-of-home placement is indicated,
- 2) when change of placement is indicated,
- 3) evaluation of the quality of placement resources, and
- 4) monitoring of the child's benefit from the placement experience.



LINKAGES BETWEEN MENTAL HEALTH AND OTHER SERVICES

Introduction

1. The Importance of the Issue

Clients of mental health programs may also be served by a host of other agencies. It was our hypothesis that a lack of coordination at all levels influences both the quality and the cost of mental health programs. The results of this evaluation have shown a number of areas in which this is true. *It is important to remember that the mental health clients who may have the least ability to deal with the system may be the most dependent upon inter-agency coordination.* For example, low income clients have few resources that they can use to contend with the number of different agencies on which they depend for income and medical support.

Fragmentation of services and objectives can compound the distress of mental health clients and lead to conflicting agency responses. For example, regulations for obtaining income support may be confusing to the mental health client, and difficult to handle.

At present, there are no management guidelines to facilitate the movement of a client, or of information about him, across agency lines. Consequently, there appear to be no procedures to monitor employee accountability for acceptable inter-agency referrals. Finally, there are few incentives for line workers of different agencies to coordinate their efforts, or even to be aware of each-other.



This section deals with the following broad concerns:

What departments most often need to coordinate efforts to provide a necessary constellation of support services to clients with urgent mental health needs?

What incentive or disincentive does the present system provide for inter-agency cooperation?

How can a variety of county services be better integrated both with other county-administered services, and with services administered by State and Federal agencies to serve the client as a "whole person" rather than compartmentalizing assistance unnecessarily?

2. Our Approach

2.1 Background

Problems of coordination may have their origin in a number of different places. Management, quality of care, relationship with support services and the like, impact substantially on the ability of county agencies to coordinate their efforts. These issues will be dealt with under other sections of this evaluation. Our approach in this section has the following limits:

- a) Office of Program Evaluation decided to limit the number of linkages examined to those which have the most direct effect on the individual client. Although a number of administrative and financial links exist between mental health administration and State departments, for example, it was considered more important to concentrate on those relationships which affect *quality of care*.
- b) We decided to concentrate our evaluation primarily on the Mental Health relationships of agencies which:
 1. Had not been previously evaluated by the Office of Program Evaluation, or are not now

being evaluated. This includes county sponsored drug and alcohol programs.

2. Were not part of the Health Care Services Agency. This refers primarily to Public Health

It was thought that the greatest benefit could be obtained by dealing with agencies which are administratively unrelated, and which thus present the most pressing problems for resolution.

The relationships which will be examined in some depth include the links between Mental Health and Conservator, Social Security Administration, Police, Welfare, Probation, Community Care Services Section, Department of Rehabilitation, and the Sheriff.

2.2 Criteria

The first objective of the evaluation team was to determine the conditions which are conducive to good linkages, and then to determine whether such conditions exist in Alameda County. Through preliminary interviews and reviews of the literature on mental health and evaluation, the following conditions were accepted as indicators of the potential for adequate linkages.

a) Mechanisms for timely recognition of mental health needs

These needs often are apparent long before actual contact is made between the client and a mental health service. There should be some effort, through outreach, consultation or training, to ensure that mental health needs can be recognized.

b) Visibility of appropriate resources

There should be readily available information about a range of services appropriate to the needs of clients.

c) Accessibility

Services should be easily accessible when needed. This includes not only geographical accessibility, but also flexibility in scheduling and operating hours to meet a variety of client needs.

d) Communication/Responsiveness

There should be ongoing communication between staff and administration of different agencies. The probability of effective communication increases if mutual perceptions of others' competence, responsiveness and willingness to cooperate are favorable.

e) Unambiguous Policies and Procedures

Policies and procedures governing the interaction of agencies and their mutual responsibilities toward clients should be unambiguous, and should facilitate continuity of care across agency lines.

It is our contention that the presence or absence of these conditions is first of all a function of the structure and operation of the total system in which many agencies operate. Therefore, it was decided to concentrate on evaluation at the systemic level, rather than at the level of individual sites. It became clear during the process of the evaluation that unless the systemic problems are addressed, adequate linkages will occur in spite of the system, not because of it.

2.3 Organization

Because the need for cooperation occurs as part of a number of processes, the decision was made to organize the evaluation around "complexes of needs". These are:

a) Continuing Care and Financial/Support

The need for income support is often most pressing, and the

possibility of non-cooperation most apparent, for the most seriously impaired mental health clients. The process of reentry into the community after hospitalization requires support from a complex of agencies providing income and other social services.

b) Criminal Justice and Community Recognition

Police and other agencies frequently deal with mental disturbances before contact is made with mental health agencies themselves.

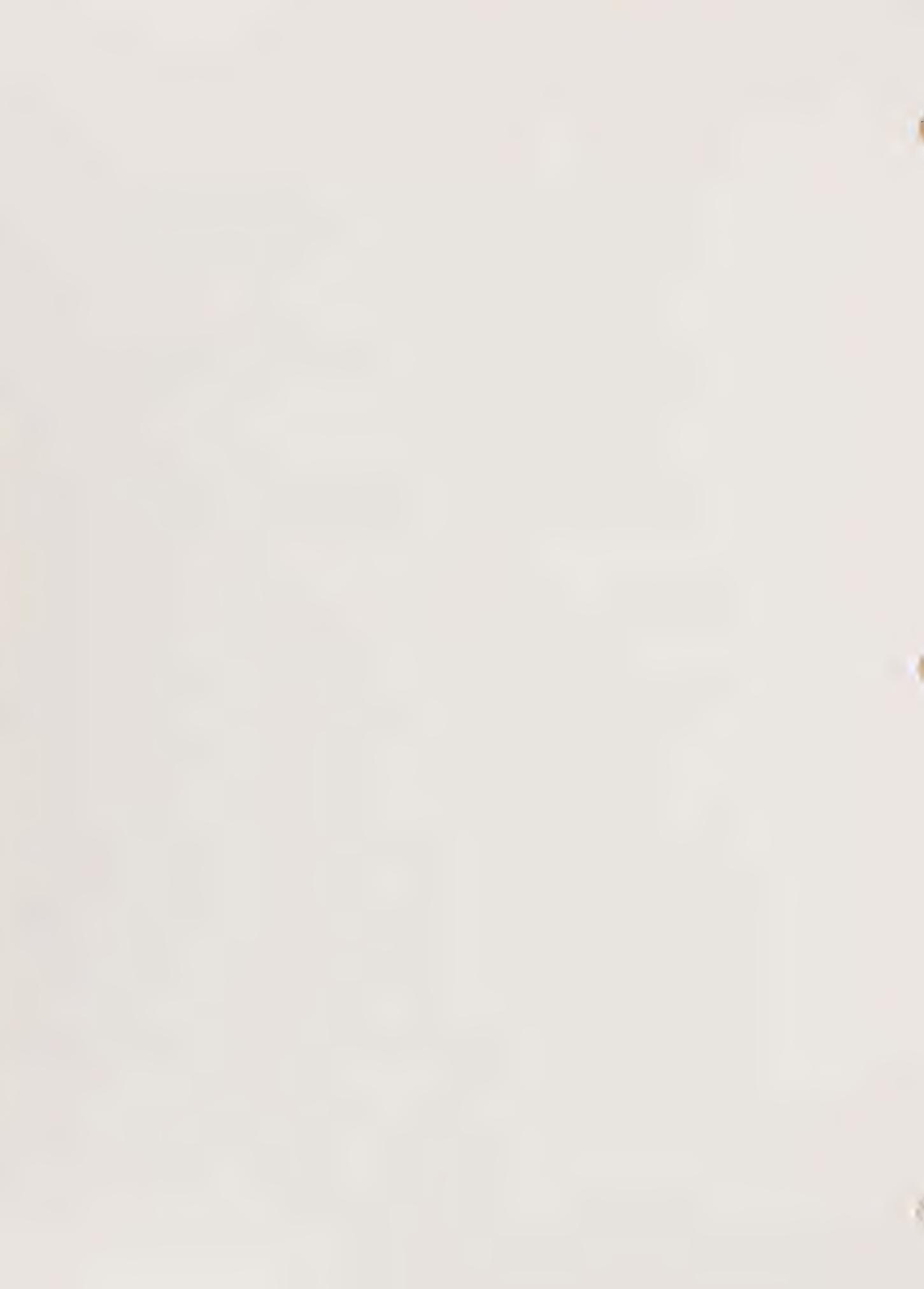
c) Children's Services

Children, even more than adults, are likely to have more than one agency involved in their care. This section will deal both with delinquency and with dependency problems.

3. Methodology

Because of the breadth and variety of functions being addressed, the most feasible methodological technique was the personal interview. Efforts were made when at all possible to ask for perceptions of issues both from mental health agencies, and from other agencies involved.

Material from interviews was supplemented with information gained from research in the areas of Management, Support, Quality and Billing and Liability. When possible, perceptions gained in interviews were checked against information in staff questionnaires. Where necessary, contracts and written policies were reviewed to provide evidence of objectives, official areas of responsibility and recommended procedures for dealing with clients or other agencies.



4. Systemic Linkage Considerations

It should be remembered that although the focus of the overall evaluation is on Mental Health Services, linkage problems between different agencies are never one-sided. Overall, the situation in Alameda County rarely fosters cooperation or coordination between agencies, particularly not at the program level. The responsibility for improving program linkages, then, rests not only with mental health, but also with all social service agencies providing services to county residents and with County administration. The intent of this section is to identify some of the areas in which the need for such efforts is most apparent. It should again be stressed, however, that improvement in these areas cannot be accomplished only through isolated efforts of the mental health service.

Continuity of Care and Financial Support: Background

We estimate that at least 50.9 percent of the client seen by mental health services are receiving public assistance of some kind. The need for financial support involves a number of agencies which must coordinate their efforts if clients are to be effectively serviced. The agencies primarily involved in financial support for mental health clients are:

Federal Social Security Administration which provides Supplemental Security Income for clients who are defined as likely to be severely disabled for periods of one year or more.

Alameda County Department of Social Services which certifies clients for MediCal eligibility, and which may be called upon to provide emergency General Assistance in some cases.

Problems in coordination among SSA, Social Services and Mental Health result in confusion for mental health clients and staff, delays in obtaining support necessary to expedite clients' reentry into the community, and often in increased costs to the County. In the end, of course, the biggest losers are the clients themselves. As previously stated, clients most in need of financial support are frequently least able to deal with the procedural requirements for obtaining it.



A. CONTINUING CARE AND FINANCIAL SUPPORT:

THE MENTAL HEALTH CLIENT AND SSI

Conclusions and Recommendations

Interagency Communication

WE CONCLUDE that lack of information in Mental Health Programs about SSA procedures and priorities results in delays in benefits for the most seriously disabled client population. Opportunities to discuss problems and policies with the local SSA Medical Evaluation Unit have not been exploited by our County Mental Health Services.

WE RECOMMEND that County Mental Health Service should concentrate on facilitating the process of certification for SSI. This effort has been primarily undertaken by the Alameda County Mental Health Association, which may have the effect of reducing Mental Health Service perceptions of the need to be actively involved.

- a) As long range objective, efforts should continue to effect changes in federally-mandated forms and procedures so that they are more easily used by the mental health client.
- b) As an immediate objective, Rehab units responsible for initiating the process of application should establish regular communication with local SSA units.

SUPPORT:

* An interview with SSA representatives states that the only requests for clarification meetings with mental-health related organizations have come from Mental Health Advocates, and from one private organization. It is significant that such requests have not been received from County Mental Health Units. One Rehab program is reported to have had an SSI representative attend a staff meeting, but no on-going liaison has resulted.

Advocacy During the Certification Process

WE CONCLUDE that there is a great need for continuing involvement of Rehab personnel with client until the entire application and eligibility process is complete. Our analysis suggests that this sort of continuing involvement is far from the rule in dealing with SSI applications.

WE RECOMMEND that Mental Health Services be responsible for clarification and dissemination of information about the necessary role of staff in the application process for SSI. Further, advocacy and continuing involvement should be made explicitly a part of the job description of all Rehab workers involved in the SSI application process.



SUPPORT:

- * Data from our clinical staff questionnaires indicates that advocacy activities take up little of Rehab clinical staff's time. Approximately 75 percent of clinical staff spend two hours or less on advocacy per week. *Approximately 70 percent state that they would prefer to spend two hours or less per week!*
- * As an index of the relative "frequency" of SSI problems compared with other mental health clients problems, Mental Health advocates states that in their first 10 months of operation, 57.7 percent of all clients had SSI related problems.

The Mental Health Client and SSI: Findings

1. Chronic clients who are severely disabled and unable to work are frequently dependent on SSI for their release from inpatient facilities. Application for SSI may be started in the hospital, but benefits cannot begin until release. The amount of the final reward is determined in part by the cost of proposed community placement. On the other hand, community Board and Care operators may be unwilling to accept clients without some assurance that SSI will be granted. The problems of timing for SSI application has the following effects:
 - a) The average patient stay in Highland inpatient of 10-14 days is not long enough to allow application for SSI to start in many cases. Unless a determination is made that the patient will be disabled for at least one year, no application may be made. Recurrent short-term hospitalizations may "disguise" the need for SSI application, although recurrent problems can be defined as eligible disability for SSI purposes.
 - b) Processing of SSI applications typically takes from two to six months. During that time, clients may be without resources. If community placement is difficult, and if alternative arrangements for interim support cannot be made, client may be released without adequate resources. One alternative, to remain in inpatient facilities until eligibility is assured, increases County costs and utilization of hospital patient days. Another alternative, to seek housing in downtown hotels and apply for general assistance, adversely affects the client's chances for recovery and also increases County costs.
2. There appears to be virtually no communication between County Mental Health agencies and representatives of the Social Security agency on any official level. Initial medical evaluation is the responsibility of a local medical evaluation unit of SSA. Therefore, some possibility exists for communication about difficulties associated with application and certification of mental health clients. A representative of the Medical Evaluation Unit states that requests for clarification of SSI problems from mental health workers are rare. As a result, completion of the medical evaluation may be delayed for



numerous reasons. For example:

Applicants may be contacted for a follow-up evaluation and examination by the SSA unit. Because of Privacy Act Restrictions, a client must either be contacted in person, or must have authorized another contact by name. Applications frequently come to the SSA office without designated contact names. SSA workers cannot leave messages attempting to contact the client unless with an authorized contact, so that the medical evaluation process may be retarded, or even stopped. It is evident that the importance of compliance with this SSI requirement is not appreciated by many mental health workers who may neglect to ensure that a contact name -such as their own- is included with the application.

3. SSA policies are confusing both to mental health workers and to their clients.

Medical history forms are complicated, and may be difficult for the chronically disturbed client to fill out. There also appears to be some confusion about where the "bottlenecks" in the SSI certification process lie. There has been a good deal of attention paid to problems that arise from the need to have income eligibility determined at a central SSA computer facility in Virginia. Computer errors and delays are frequently cited as problems. However, if the minimum time for medical evaluation in Alameda County is 45 days, this suggests that efforts should be made to expedite this process, since some of the problems leading to greater than 45 days processing (i.e., follow-up above) could be corrected at the county level.



Continuing Care and Financial Support: Mental Health and Social Services

Conclusions and Recommendations

Development of Linkages mechanisms by Mental Health Service

WE CONCLUDE that the Southern Region plan for mobile PST's shows that some consideration has been given to the problems faced by mental health clients in dealing with Welfare regulations. However, the lack of such efforts in other parts of the County may have significant effects on Medical revenues available within the County.

WE RECOMMEND that a program similar to that implemented by South County be developed for North County. This would have to involve enough staff to be able to visit each site frequently. PST responsibilities should include familiarizing all clerical staff of individual units with Welfare regulations, procedures, timetables, and office locations.

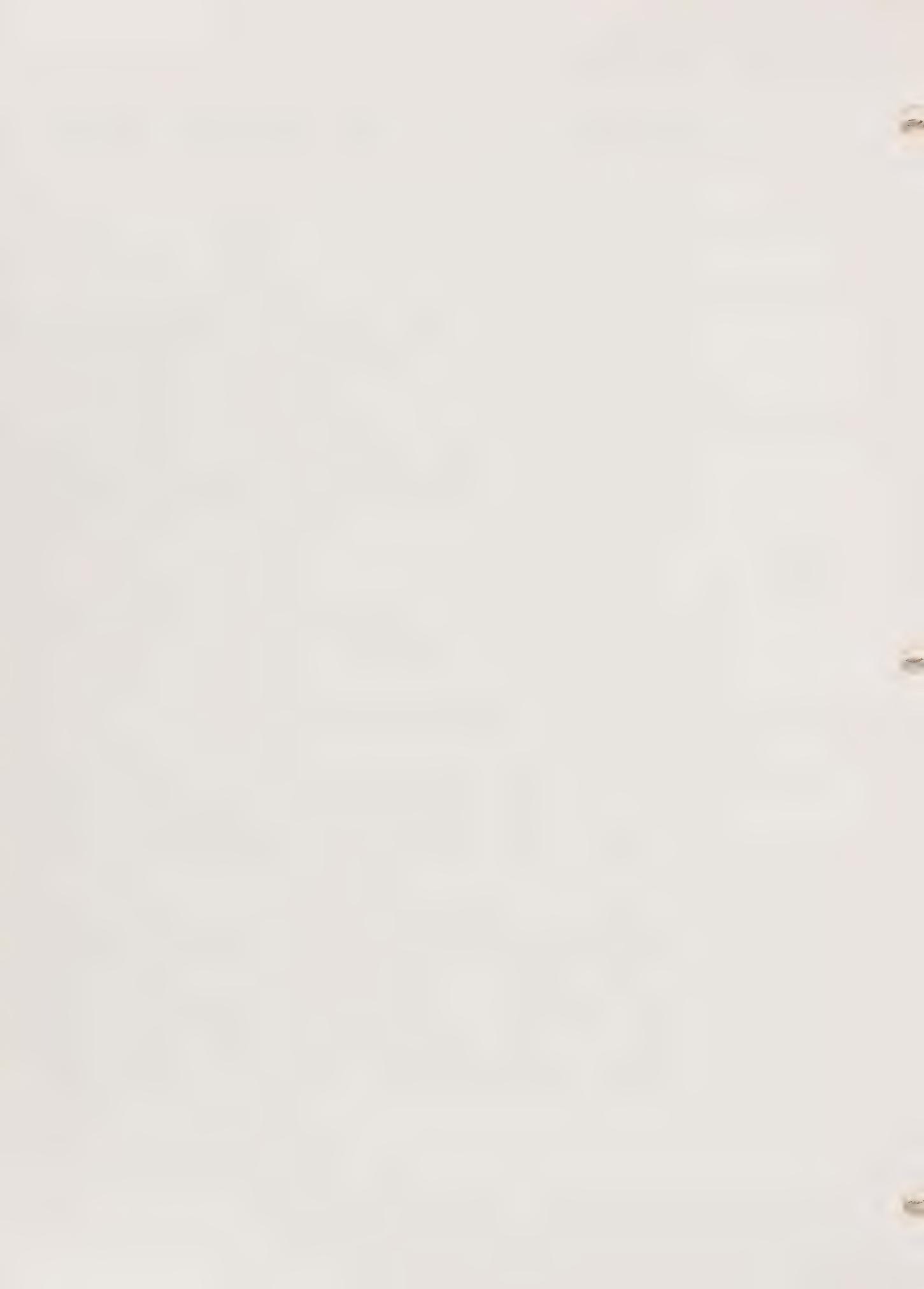
SUPPORT:

- * The need for such linkages is shown in cost data from the Billing and Liability Section of this evaluation.

Mandated Coordination at the Administrative Level

WE CONCLUDE that the dependence of Mental Health Service on Social Services for Medical certification makes it imperative that administrative coordination exist. That coordination has been virtually non-existent. This has definite impacts on Mental Health Services ability to perform its own functions efficiently.

WE RECOMMEND that the CAO be responsible for mandating this relationship in addition to actively encouraging relationships with other agencies where efforts on the part of the agencies themselves have proved ineffective. The recently-formed Human Services Council may provide one mechanism by which this can be accomplished. Mental Health Services is not now specifically included in the Council. We recommend that it be included in the future. However, the need to mandate coordination at the staff level, as well as among administrators of agencies, remains and must be immediately addressed.



Mental Health and Social Services: Findings

In general, there is little program staff communication, and virtually no administrative link between Mental Health Services and Social Services. This link is important because of the role of Social Services in determining Medi-Cal eligibility for mental health clients.

1. Lack of Welfare Care Responsibility

The switchover of all adult aid programs to Social Security and administration by the Federal agency in 1974, has effectively ended continuing case responsibility for Welfare caseworkers dealing with mentally disturbed clients. There is, therefore, little incentive to maintain contact with Mental Health programs at this time. Staff cutbacks and high caseloads in Welfare leave the burden of initial contact to eligibility technicians. These workers have neither the training nor the responsibility to diagnose the special needs of mental health clients.

2. Conflict in Policies and Procedures

The Billing and Liability section of this evaluation outlines the cost to the County from conflicting policies regarding UMDAP and MediCal eligibility. Welfare time limits for application may be difficult for mental health clients to meet. Requirements for submitting labels for payment of MediCal claims are poorly understood by County mental health workers.

Although some assistance is given to mental health clients through PST workers in Highland and Fairmont Hospitals, clients in the districts have often been dependent on clerical staff of various Mental Health units. A recent attempt has been made in Southern Region to establish a link with Welfare process through traveling PST's who visit each Mental Health unit to assist in determining MediCal eligibility.



3. Lack of Administative Link

The absence of administrative linkages between Mental Health and Welfare make it difficult for Mental Health to use available data kept by Welfare to help determine MediCal eligibility. A recent meeting with CAO and HCSA staff cited the fact that data are kept by Social Services that would allow mental health staff to determine whether a patient was MediCal eligible in a given month. The Department of Social Services has declined to change the way in which that data is arrayed to make use by Mental Health staff possible.



Continuing Care and Financial Support: Mental Health and Community
Care Services Section (CCSS)

Conclusions and Recommendations

CCSS Staff Utilization

WE CONCLUDE that current contract and administrative policies do not encourage cooperation or mutual appreciation between Rehab and CCSS workers. The present contract structure allows variation in expectations among districts, and underutilized CCSS staff in service delivery areas which are already under-staffed by mental health professions.

WE RECOMMEND that contracts between Rehab services and CCSS workers should be formulated to ensure that advantage is taken of the professional qualifications of CCSS staff. Our data on staffing patterns indicates that less than half of Rehab staff are professionals. This suggests that staff with professional qualifications, whether Rehab or CCSS workers, should be able to concentrate on therapeutic activities for those clients who will benefit from them.

SUPPORT:

- * Interviews with CCSS staff and administration indicate high dissatisfaction with current relationships in several areas.
- * Data on staffing patterns for patterns peculiar to Rehab services.
See also associated recommendations for the use of professional and paraprofessional personnel (under "Impact").

Fragmentation of Responsibility

WE CONCLUDE that a "piecemeal" orientation toward clients presently exists when responsibility for the ongoing therapeutic work with the client is terminated after board and care placement. A concentration on placement, without involvement in treatment, provides no incentive for continued concern with the welfare of the client.

WE RECOMMEND that professional staff be encouraged in all cases to continue involvement in the treatment of the client. Responsibility should not be tied to funding sources or to the delivery of only one isolated service such as residential placement.



SUPPORT:

- * Contact addenda explicitly state the conditions under which CCSS staff may be asked to close their own cases on client.
- * Interviews with CCSS staff support the contention that present policies are a disincentive to morale and responsibility.

Mental Health and Continuing Care Services Section (CCSS): Findings

There is a serious absence of cooperation between Mental Health Services and Community Care Services Section. This results in poor staff utilization and in poor service to the most seriously-disabled client group.

1. Underutilization of CCSS Staff

MHS - CCSS contracts give Rehab service chiefs administrative authority over CCSS workers in their units, but no line authority. As a result, there is little accountability between these closely associated agencies. In many cases, CCSS workers are underutilized. They are often required to do only residential placements, or less professionally demanding work than their training qualifies them to do. This results in continuing friction between County and State workers, and reduces the incentives to provide adequate client care.

2. Fragmentation of client responsibility

Contract addenda are negotiated separately by individual Rehab chiefs with CCSS staff in their own unit. They thus appear subject to the possibility of being influenced by personalities rather than program demands. CCSS workers in Tri-City and Valley districts must close their own cases on client when Family Care Funds (which they provide) are no longer needed. It is then up to the discretion of the Rehab chief whether to allow the CCSS worker to continue responsibility for the client. This situation can result in a "piecemeal" approach to clients, rather than encouraging continuing involvement.



3. In the past, the State Department of Health has included opt-out provisions in which Counties may terminate their relationship with CCSS as a State entity. Although there is presently a moratorium on opt-out, the future possibility is frequently discussed as a means of eliminating frictions between CCSS and Mental Health workers in some districts. At this time, this discussion serves only to increase tensions between staff in these units.

Continuing Care and Financial Support:

Dependency - Mental Health and the Conservator

Conclusions and Recommendations

Defining Responsibilities

WE CONCLUDE that the legal limits of the Conservator's authority have not been adequately defined at the staff level. This results in inappropriate demands being made on the Conservator's Office in cases of difficult patients, or in inadequate responsibility being taken by Mental Health workers, and chronic disagreement between staff of the two agencies about placements.

WE RECOMMEND that immediate efforts must be made to clarify the individual responsibilities of Conservator and Mental Health at the staff level. Since these relationships involve not only County staff, but also State CCSS staff, CCSS administration should be included in all administrative communication concerning the conservator.

SUPPORT:

- * Interview with Conservator points out problems in defining proper role. This includes lack of communication with CCSS administration.
- * Recent progress report of Director of Mental Health Services acknowledges the lack of communication until now, and objectives for improving it in the future.

Dependency: Mental Health and Conservator: Findings

Section 5350 of the Welfare and Institutions Code allows the option of Conservatorship for the estate of the Conservatee, or for his person only. Alameda County chooses to regard Conservatorship as applying only to the person. There appears to be confusion among Mental Health workers about the extent of the conservator's legal and therapeutic role. This may result in misconceptions about proper responsibilities, and in lack of attention being paid to the needs of conservatees in community residences.

1. Roles and Responsibilities are Poorly Defined

The role of the Conservator in initiating application for SSI, in making placements, and in maintaining contact with Conservatees is poorly understood by Rehab workers who deal with Conservatees. The Conservator regards all of these activities as being part of the treatment process, and therefore not the legal responsibility of his office. Large caseloads for investigation make it difficult for Conservator's staff to maintain follow-up relationship with Conservatees in Board and Care or L facilities. However, Conservators frequently receive calls from Board and Care operators asking for assistance in handling difficult cases. This indicates that the limits of responsibility are not understood, either by Rehab placement workers or by operators.

2. Lack of Communication Between Conservator and Mental Health Administration

There has been no systematic attempt to establish communication between the conservator and Mental Health Administration, although this has been named as an objective by the new Mental Health Administration. Without an administrative link, there is little assurance that whatever clarification of responsibilities is attempted will be distributed to all affected mental health units. In addition, direct dealing between Conservator and Mental

Health workers often involves CCSS, as well as county rehab staff. To the extent that communication problems exist in that relationship, the probability of clarification decreases.

Napa and Highland Inpatient staff, along with County Rehab and allied CCSS workers, frequently report disagreement and frustration with Conservatorship staff in obtaining approval by the Conservator of any residential or "L" facility placements planned by treatment staff, usually at the time of a conservator's discharge from the hospital. The Conservator has a legal responsibility for the well being of the conservatee both in the hospital and the community, and disagreements often amount to differences of opinion about the adequacy of particular facilities. A section of the Lanterman - Petris - Short Act (Section 5359) provides in part for resolution for these disputes, and could provide some model for a specific mechanism to be developed jointly by Mental Health and the Conservator for disagreements around placement.



Continuing Care and Financial Support:

Mental Health and the Department of Rehabilitation (DR)

Conclusions and Recommendations

Establishment of Prevocational Programs by Mental Health Services

WE CONCLUDE the mental health units have relied heavily on DR contracts for vocational rehabilitation of clients. This acts to narrow the options for all but the least impaired mental health clients. There have been few prevocational programs initiated by mental health, and these have been primarily due to efforts of individuals, rather than to a commitment to such programs by the mental health agency.

WE RECOMMEND that Mental Health Services should have primary responsibility for initiating prevocational programs for clients. The Southern Region Vocational Program now functioning in Eden District could be used as a possible model for these programs. This program utilizes a number of community resources, and Federal CETA funding in a four-step training process. The County should further explore the availability of alternative funding sources for these programs.

SUPPORT:

- * Interviews with County Mental Heath staff confirm the problems of autonomy and cooperation.
- * Communication between DR and mental health administration stresses the incentives to select "successful" clients if budget requests are not met.



Mental Health and Department of Rehabilitation (DR): Findings

Reentry into the community frequently requires vocational training for the client. County contracts with DR provide the bulk of this training. Problems arise in cases where mental health clients are not capable of participating at the level of training provided by DR. There is a substantial gap between services offered by DR and those offered by Mental Health Rehab.

Autonomy

Because Mental Health Service contributes only about 20 percent of the DR County budget, DR insists on considerable autonomy for its own rehab counselors. Original contract efforts to involve counselors in the functions of Mental Health Rehab Units have been gradually modified to minimize that involvement. This reduces incentives for ongoing staff communication between agencies.

Contract Funds Limit the Clients to be Served

The amount of funding for DR influences the possible length of treatment. Therefore, the more disabled the client, the greater the chances that no DR services will be available. This may, in fact, increase the "gap" between DR - eligible clients and others.

Prevocational Programs Provide a Crucial Link

Prevocational programs have not been a high mental health priority. This may mean that clients who could potentially be served by DR (after some preparation) never have that opportunity. For example, there is a strong need to train clients in the mechanics of job interviews, getting to work

on time, etc. These skills would make clients better able to take advantage of DR programs.



B. MENTAL HEALTH AND CRIMINAL JUSTICE AGENCIES: RECOGNITION IN THE COMMUNITY

Conclusions and Recommendations

WE CONCLUDE that Alameda County Mental Health Services do not presently have the capability to effectively work with police services in a fashion allowing for maximum use of mental health staff in crisis situations.

WE RECOMMEND that the County develop a 24-hour crisis intervention capability service. It is imperative that services be available when the crisis situation occurs. This refers not only to operating hours, but also to location. Response to crisis situations should be made as rapid as possible through decentralization of service capability.

SUPPORT:

- * Hours of service for most crisis units do not include nights and weekends - the most likely time for disturbances to occur.
- * Lack of adequate police linkages to crisis intervention programs for all but the most obviously disturbed clients is corroborated by data in our evaluation of quality.

Linkages at the Program Level

WE CONCLUDE that there are few continuing linkages at either the program or administrative level between local police and mental health units - even though both agencies frequently are concerned with the same clients.

WE RECOMMEND that County Mental Health Administration be responsible for informing local police departments on an ongoing basis about services offered by mental health. Resource manuals should be revised and updated at regular intervals. Staff communication, not presently stressed, should be encouraged in order to anticipate community problems.

SUPPORT:

- * Nearly 75 percent of clinical staff of crisis services responded "rarely" to the question "How often do you find out about community problems through the police?"
- * Review of training and resource manuals from local police departments shows few mental health resources listed other than "Psych Emergency". Oakland Police have acquired a resource manual compiled by Mental Health Advocates, but have no information directly from Mental Health Services.

Mental Health and Criminal Justice Agencies: Background and Findings

Local police often serve as initial points of contact with disturbed persons. For this reason, it is particularly important that effective linkages be established between mental health units and local police departments. The following issues are examples of the extent of coordination which now exists.

Official Linkages - Delayed Response

The official Linkage in North County area is between local police and Highland Psychiatric Emergency Service (HPES). The primary problems appears when police apprehend a person and wish to detain him/her under Section 5150 of the Welfare and Institutions Code. In order for a person to be taken to HPES, he must be judged either gravely disabled, or danger to himself and others. Police feel that people are frequently released by HPES because the worst of the crisis has passed by the time they get there.

Official Linkages - Visibility, Availability of Resources and Responsiveness

Resource manuals showing the availability of mental health services are occasionally maintained by police departments. However, these are usually confined to psychiatric Emergency information. Knowledge of services offered by other potentially useful units (particularly Crisis Services) occurs, if at all, at the level of the individual patrolmen, in most cases.

Apparently there have been few offical efforts on the part of MHS to augment information maintained by the police themselves, or to establish linkages between crisis programs and the police who service each geographic area. However, some instances do exist. For example, Berkeley Albany Reachout Team (BART) assists Berkeley police in crisis situations. However, current budget and policy restrictions limit the ability of BART to respond immediately at the scene of Crisis.



The greatest continuing need of police is mental health assistance in dealing with "415's" - family disturbances. These situations frequently involve persons in severe states of crisis. They are time consuming, and regarded by the police as being extremely dangerous circumstances.

Police cite as most important the lack of available crisis services, and the need for involvement of mental health personnel at the scene. The City of Hayward provides a possible model for future plans in this area. Project Outreach is funded and administered through the Hayward Police Department, but is staffed by mental health professionals. Staff accompany police on family disturbance calls and establish an immediate link with the disturbed client.

In order to increase the ability of mental health services to respond to such situations, Project Outreach staff have been working with South County Mental Health Administration on a proposal to equip mobile assistance units to serve the entire South County Region from Fairmont Psychiatric Emergency. Santa Clara County also utilizes this team approach of mental health and police personnel in dealing with family disturbances.



MENTAL HEALTH AND THE ALAMEDA COUNTY SHERIFF (SANTA RITA)

Conclusions and Recommendations

WE CONCLUDE that because of the short time of operation of the Criminal Justice Unit at Santa Rita, no recommendations for change should be made at this time. Future planning for CJMHSU indicates that efforts will be made to increase involvement at Santa Rita between mental health and Sheriff's department personnel.

The need for adequate facilities for screening and evaluation has been discussed before the Board of Supervisors. This need still exists. However, recommendations for change at the program level would be premature.

SUPPORT:

- * The prison environment may aggravate or cause severe mental distress for the inmate. For this reason, it is important that efforts be made to diagnose and treat mental problems before they become unmanageable. Until recently, there have been few attempts made to coordinate efforts between mental health and Santa Rita.

The establishment of the Inter-Agency Coordinating Council in August, 1975, and the recent organization of the Criminal Justice Mental Health Screening Unit at Fairmont Hospital were intended to deal with perceived lacks in communication and coordination. These organizations have the potential to improve substantially the quality of linkages at both levels. In view of part difficulties, however, regular authority for developing and coordinating service delivery might profitably come from a single administrative person who is not inclusively identified either as responsible only to the Sheriff or only to Mental Health.

C. CHILDREN'S SERVICES

Conclusions and Recommendations

Intervention and Treatment in Juvenile Hall

WE CONCLUDE that mental health staff are not able to provide an adequate level of treatment services to Juvenile Hall. This has the effect of increasing staff tension, and decreasing the probability that cooperation between the two staffs will be maintained. We further conclude that the primary mental health functions relating to the juvenile justice system are:

- 1) handling of crisis in detention settings,
- 2) detection of juveniles with mental health problems at intake points of the juvenile justice system (Juvenile Hall)
- 3) screening of referrals for diagnostic evaluations and/or psychotherapy,
- 4) input into decision-making for children acknowledged to have psychological problems as well as anti-social behavior patterns,
- 5) consultation to juvenile institutions,
- 6) diagnostic evaluation,
- 7) therapeutic treatment, and
- 8) community advocacy, prevention, and out-reach.

WE RECOMMEND that a core staff of five personnel be retained as the Probation Guidance Clinic and based at Juvenile Hall with the mandate to perform the first four functions listed in the previous conclusion. We recommend that regular and on-going consultation to the juvenile institutions be discontinued. We further recommend that two staff from the present PGC be re-allocated to Eden Children's Center to provide diagnostic evaluations and psychotherapy on a "charge-back" basis to wards of the Juvenile Court and in the custody of the juvenile institutions. We finally recommend that the remaining three staff members be re-allocated to Tri-City, Valley, and Central Children's Services.



SUPPORT:

- * Our study of the impact of consultation services indicated that consultations to the juvenile institutions are largely ineffective.

Crisis and case-finds must be based where those needs arise - at Juvenile Hall - the basis of our recommendation that a core of PGC be retained there.

The number of diagnostic evaluation and psychotherapy referrals could be greatly reduced by careful screening and thorough consultation with the referring probation deputy.

Advocacy, out-reach, and preventative efforts should be based in the various communities with their own, unique resources which promote or deter delinquency.

Eden Children's Center is located closely enough that diagnostic evaluations and psychotherapy could be offered to juvenile detainees from that setting. The budget of that service should take into account services provided the probation department through the charge-back of costs.



Mental Health and Juvenile Placements

WE CONCLUDE that present policies and divisions of authority and responsibility for placement jeopardize the welfare of a minimize the benefit to children who are placed out of their homes by the Juvenile Court for psychological reasons.

WE RECOMMEND that negotiations be scheduled between the Judge of the Juvenile Court, the Chief County Probation Officer, and the Local Mental Health Director. The Director of the Probation Department's Placement Division and a Coordinator of Children's Service should also be included in these negotiations. Issues to be resolved include:

- 1) responsibility for deciding when out-of-home placement is indicated,*
- 2) when change of placement is indicated,*
- 3) evaluation of the quality of placement resources, and*
- 4) monitoring of the child's benefit from the placement experience.*

SUPPORT:

Our interviews indicate that:

- * PGC staff are asked to evaluate children in terms of need for placement yet are given no indications of what placements might be available.
- * Except in rare instances, PGC have no direct experience with the placement resources and are furnished only "fact sheet" summaries of the institutions, foster homes, and group homes where children are placed.
- * Except in instances when children are placed in Short-Doyle funded facilities, PGC staff are seldom consulted when a change of placement is made.
- * The investigating probation officer may or may not follow PGC's recommendation in the recommendation to the Juvenile Court, or the



Juvenile Court may or may not follow PGC's recommendation, and a justification for that action is seldom, if ever, furnished PGC.

- * Probation officers in the Placement Division are not trained mental health practitioners and therefore cannot be expected to judge placement resources from the standpoint of mental health treatment.
- * There are no incentives - rather, there are obstacles, - for foster parents or those in charge of institutions or group homes to contact the PGC clinician who recommended the placement when difficulties arise. As a consequence, children who present difficulties are often returned to Juvenile Hall with no opportunity for intervention on the part of the clinician, after which the child is labeled as a "placement failure", making subsequent placement even more difficult.
- * When a child is succeeding at a high-cost placement, the probation officer may move the child to a less expensive placement, and so on, until the child does not succeed, is returned to Juvenile Hall, labeled a "placement failure", and so on.
- * Children who are difficult to place (i.e., those who have committed sexual offenses, committed arson, are homosexual or transvestite or suspected of either) may wait for months for placement, during which it is rare for the clinician to be called in to explain the behavior patterns of a child to a prospective placement resource. One highly talented young man whose transvestite tendencies were associated with his love for the theatre, was confined for almost ten months



before a PGC clinician, on his own initiative, found a suitable placement in Southern California. Clinicians who go out of their way to locate suitable placements for difficult youngsters are often met with resentment for their effort and are felt to be "meddling".

* It is rare for the parents of a child who has been placed to be referred for treatment during the period of placement. As a result, the child may return home having grown considerably only to find conditions at home unchanged, which conditions contribute to the child's anti-social behavior in the first place, with the result that the behavior, and the legal ramifications, repeat themselves.

* Probation officers in the Placement Division are expected to monitor a child's progress in a placement despite the fact that the officer may only visit the placement once a month or less during which he may spend less than an hour with the child. Practically never is PGC asked to re-evaluate a child and/or the home before a decision to terminate placement is made.



Children's Services: Findings

Children by virtue of their legal status, typically have more than one agency involved in their care. This makes the need for inter-agency cooperation crucial.

Probation Guidance Clinic (PGC) and the Probation Department:

Background and Findings

Problems of coordination between PGC and Probation are symptomatic of a pervasive problem in children's services. There is no clear definition of the authority or responsibility of each agency during the treatment or evaluation phase of involvement with the client. However, Probation policies serve to curtail involvement by mental health in the placement of clients.

Priorities of both agencies may be in conflict. Juvenile Hall staff see their primary responsibility as custodial. The mental health model emphasizes treatment. Confinement, which may be demanded from the legal point of view, can also be detrimental to the mental health of the client. The "balance" between these two orientations is poor.

Coordination in Juvenile Hall

Probation authorities have ultimate authority over the client in Juvenile Hall. However, because mental disturbances and crisis situations are frequent among the Hall's population, crisis intervention involvement by PGC staff is often requested.



PGC operates under a number of constraints: the first responsibility of the unit is to the courts for diagnostic evaluations. These consume large amounts of staff time. Given this constraint, PGC staff is not adequate to provide full-time crisis intervention or treatment capability to the Hall. The situational nature of the contact between PGC and Probation staff discourages favorable staff relationships. Probation staff working on shifts may be unaware of problems which have occurred on other shifts. This means that clients with known mental health problems or involvement may go unrecognized when brought to the Hall.

Placement

PGC staff have no continuing relationships with clients who are placed in residential facilities by Probation. For example, there is no contact between mental health staff and operators of group or foster homes. The fact that many of these homes are outside of the County makes continuing involvement in monitoring former clients' progress difficult, if not impossible.

Probation has total authority in placement operations. The role of PGC is advisory only. In addition, PGC is not allowed to recommend specific placements (for example, they may say "24-hour treatment facility", but may not say "Fred Finch"). This may serve to minimize the influence that PGC staff have in determining eventual placement. It also increases tension between agency staffs.

Funding

Dollars and responsibility do not follow the client in residential placements. For example, mental health has responsibility for clients only if Short-Doyle



funds are being used for payment. For example, if a client is placed in Fred Finch, and must leave, mental health's authority (and, essentially, involvement) ends with a change inⁱ the funding agency.



Volume II

Section X: Effects of present Napa State Hospital utilization on Alameda County's Mental Health Services

This subject was described in our final work program as a major issue for evaluation, but was not studied because the Mental Health Service had already identified Napa utilization as their top priority for intensive investigation.

In fact, major investments of Mental Health Service administrative and service staff time have been made in evaluation efforts, including the planning and implementation of ad hoc programs intended to rapidly diminish use of the State hospital and minimize the effects of sharp penalties imposed by the State on Alameda County for overutilization.

We have reviewed the Service's evaluation documents of Napa and Highland inpatient utilization, and are aware of program activities in the past several months. We are aware of the severe disruption of outpatient programs lending many of their staff to these regionally-directed efforts to change the entire psychiatric inpatient system for the County. We made no attempt to judge these efforts at this time.

We consider two hypotheses for this issue in our work plan as proven by events of the past six months, namely that current use of Napa State Hospital (1) results in inefficient and ineffective mental health services for Alameda County patients and (2) limits the ability of the Mental Health Agency to address other community mental health priorities.

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